

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 1 1960

=60-001421

DED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 269 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>1925</b>	c. CITY OR TOWN <b>Lenexa</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4228 Agnes Street</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>9311 Noland Road</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Homer</b> Middle <b>F.</b> Last <b>Bryant</b>			4. DATE OF DEATH Month <b>1</b> Day <b>15</b> Year <b>1960</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <b>Married</b>	8. DATE OF BIRTH <b>July 6 1890</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. ROUTE MAN.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>DAIRY</b>	11. BIRTHPLACE (City and state or country) <b>Purdy Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>JACK P. BRYANT</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>ANNA L.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>486-09-6280</b>	17. INFORMANT <b>ANNA L. Bryant - 9311 Noland Rd</b>	Address <b>Lenexa Ks.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Blows &amp; Hemorrhages resulting from crushing injury of chest with ruptured liver &amp; lung, ruptured diaphragm &amp; multiple rib fractures</b>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>car was crushed over him</b>
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20c. TIME OF INJURY Hour <b>1-15-60</b> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	20f. CITY, TOWN, OR LOCATION <b>Kansas City Johnson</b>	COUNTY <b>MO</b> STATE
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw him alive on \_\_\_\_\_  
--Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Dr. C. L. ...</b>	22b. ADDRESS <b>6627 Park St Over</b>	22c. DATE SIGNED <b>1-16-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-19-60</b>	23c. NAME OF CEMETERY OR CREMATOR <b>Floral Hills</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City MO.</b>
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24. FUNERAL DIRECTOR <b>Floral Hills Memorial Chapel</b>	ADDRESS <b>Kc Mo</b>	25. DATE RECD. BY LOCAL REG. <b>1-18-60</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Thomas W. Holson

Licensed Embalmer No. 4889

P. O. Address A. C. 2/0.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.