

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-004317

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Registration District No. _____ Primary Registration District No. 541 Registrar's No. 149 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in lb <u>5 DAYS</u>	c. CITY OR TOWN <u>Jennings</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Co. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2522 Center St.,</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle _____ Last <u>Bryan</u>			4. DATE OF DEATH Month <u>1</u> Day <u>14</u> Year <u>60</u>			
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/82</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>Belgrade, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Scott Evans</u>	13b. MOTHER'S MAIDEN NAME <u>Evelyn Ramsey</u>	14. NAME OF HUSBAND OR WIFE <u>Thomas Bryan</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Helen Tullbck, 2522 Center Ave.,</u>
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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) <u>cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive Cardiovascular Disease</u>	
	DUE TO (c) <u>Arteriosclerotic Heart Disease</u>	

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input 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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 1-9-60, to 1-14-60 and last saw ^{her} him alive on 1-14-60
Death occurred at 6:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u>	22b. ADDRESS <u>601 So. Brentwood</u>	22c. DATE SIGNED <u>1/14/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>1/17/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Joseph Chapel Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Quaker, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Emil J. Heitzenroeder, 8319 Hallsferry</u>	25. DATE RECD. BY LOCAL REG. <u>1-15-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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

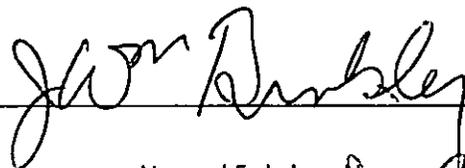
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. _____

P. O. Address _____

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Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.