

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Salem	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 120 So. College Street.,	

3. NAME OF DECEASED (Type or print)	First ROBERT	Middle WILLIAM	Last BRYANT	4. DATE OF DEATH	Month AUGUST	Day 21	Year 1960
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/13/1933	9. AGE (last birthday) 27	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Western Union	11. BIRTHPLACE (City and state or country) Iuka, Illinois.	12. CITIZEN OF WHAT COUNTRY U.S.A.		

13a. FATHER'S NAME W. C. Bryant	13b. MOTHER'S MAIDEN NAME Clara E. Thomas	14. NAME OF HUSBAND OR WIFE Lidia Bryant
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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) Yes W.W. 11	16. SOCIAL SECURITY NO. 335-26-7336	17. INFORMANT W. C. Bryant, Salem, Illinois.	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) UREMIA CHRONIC RENAL FIBROSIS		4 1/2 MONTHS
DUE TO (b) BILATERAL URETERO-HYDRONEPHROSIS		4 1/2 MONTHS
DUE TO (c) CHRONIC RENAL DISEASE, TYPE UNDETERMINED		4 1/2 MONTHS
DUE TO (c) BLADDER NECK OBSTRUCTION 606x		YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) HYPERPARATHYROIDISM	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 checked="" type="checkbox"/> NO <input 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	Month, Day, Year
	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 AUG. 17, 1960 to AUG. 21, 1960 and last saw her/him alive on AUG. 21, 1960
Death occurred at 3:55 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. P. Vermillion, M.D.</i> (Degree or title) M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 8/22/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8/24/60	23c. NAME OF CEMETERY OR CREMATORY East Lawn Cemetery	23d. LOCATION (City, town, or county) Salem, Illinois.	(State)
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24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.,	25. DATE RECD. BY LOCAL REG. AUG 23 1960	26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

EX-100-10-1-10-1

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 Spencer Kable

Licensed Embalmer No. 4596
P. O. Address St Louis

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.