

MOURNERS DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-045479

AMENDED

Registration District No. 884- Primary Registration District No. 3099 Registrar's No. 115 STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <u>Linn</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u> | | Length of stay in 1b <u>5 yrs.</u> | c. CITY OR TOWN <u>Brookfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>510 Shelby St.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>510 Shelby St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>FLOYD WEST BRYANT</u> | 4. DATE OF DEATH Month Day Year <u>December 15, 1961</u> |
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|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--------------------------------------|------------------------|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-4-1905</u> | 9. AGE (last birthday) <u>56</u> | IF UNDER 1 YEAR Months Days Hours | IF UNDER 24 HR Min. |
|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--------------------------------------|------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rep-Technician</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Am. Breeders Service</u> | 11. BIRTHPLACE (City and state or country) <u>Grundy Co., Missouri</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Charles Moses Bryant</u> | 13b. MOTHER'S MAIDEN NAME <u>Malinda McLey</u> | 14. NAME OF HUSBAND OR WIFE <u>Dorothy Bryant</u> |
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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) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address <u>Mrs. Dorothy Bryant, Brookfield, Mo.</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>Hemorrhage, same.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Acid secretion of stomach.</u> | |
| | DUE TO (c) | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cachexia same.</u> | 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 |
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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.) <u>—</u> |
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| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>—</u> |
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| 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.) <u>—</u> | 20f. CITY, TOWN, OR LOCATION <u>—</u> | COUNTY <u>—</u> | STATE <u>—</u> |
|--|--|--|--------------------|-------------------|

21. I attended the deceased from May 1961, to Dec. 15 and last saw her alive on Dec. 15, 1961
Death occurred at 2:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>R. W. Babcock M.D.</u> | 22b. ADDRESS <u>Brookfield Mo.</u> | 22c. DATE SIGNED <u>12/15/61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Dec, 18, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Resthaven Mem. Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Trenton, Missouri</u> |
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| 24. FUNERAL DIRECTOR <u>Wright Funeral Home, Brookfield, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>12-16-61</u> | 26. REGISTRAR'S SIGNATURE <u>Anna Watson</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

INSTEAD OF

ITEM NO. SHOULD READ

JAN 16 1962

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed C. W. Wright

Licensed Embalmer No. 5167

P. O. Address Brookfield, Mo.

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.