MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-006431
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 804

FILED FEB 28 1962

AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: KANSAS CITY — Length of stay in 1b: 11 DAYS
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): GREAT OAKS CHRST SCIENCE NURSING HOME — Inside Limits: Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: IOWA b. COUNTY: Des Moines
c. CITY OR TOWN: DES MOINES — Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): 733 10th STREET — Reside on Farm: Yes ☐ No X

3. NAME OF DECEASED (Type or print): First LUCILE Middle H Last BRYSON
4. DATE OF DEATH: Month FEBRUARY Day 11 Year 1962
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married X Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: JAN 13, 1899
9. AGE (last birthday): 63 — IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HR: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): OSCEOLA, IOWA
12. CITIZEN OF WHAT COUNTRY: U S A
13a. FATHER'S NAME: WILLIAM H HOLMES
13b. MOTHER'S MAIDEN NAME: LILLE TROTTER
14. NAME OF HUSBAND OR WIFE: J A BRYSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: J. A. BRYSON Address: DES MOINES, IOWA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): unknown — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Christian Scientist
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from ___, to ___ and last saw her/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: H L Dwyer (Degree or title) MD
22b. ADDRESS: City Hall Kansas City Mo
22c. DATE SIGNED: 2/12/62

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-12-62
23c. NAME OF CEMETERY OR CREMATORY: —
23d. LOCATION (City, town, or county) (State): Des Moines, Iowa

24. FUNERAL DIRECTOR: Freeman Mortuary ADDRESS: Kansas City, Mo.
25. DATE RECD. BY LOCAL REG.: 2-12-62
26. REGISTRAR'S SIGNATURE: Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

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 Ralph O. Grubb

Licensed Embalmer No. 5004

P. O. Address K. C. 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.