

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-019695

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 745

FILED MAY 22 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>WEBSTER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		c. CITY OR TOWN <b>SEYMOUR</b>	
Length of stay in 1b <b>18 DAYS</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>ST. JOHNS HOSP'</b>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES BARTON BRYAN</b>			4. DATE OF DEATH Month Day Year <b>5 - 14 - 63</b>
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"/>	8. DATE OF BIRTH <b>NOV. 22, 1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED FARMER</b>	9. AGE (last birthday) <b>78</b>
11a. FATHER'S NAME <b>JAMES BRYAN</b>		11b. MOTHER'S MAIDEN NAME <b>MARTHA BRIKEY</b>	11c. IF UNDER 1 YEAR Months Days Hours Min.
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>NO</b>		12b. SOCIAL SECURITY NO.	12c. IF UNDER 24 HR Months Days Hours Min.
13a. FATHER'S NAME <b>JAMES BRYAN</b>		13b. MOTHER'S MAIDEN NAME <b>MARTHA BRIKEY</b>	13c. CITIZEN OF WHAT COUNTRY <b>STATE OF KANSAS U.S.A.</b>
14a. NAME OF HUSBAND OR WIFE <b>OPAL</b>		14b. NAME OF HUSBAND OR WIFE <b>OPAL</b>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia (See Part II)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>few days</b>
DUE TO (b) <b>Congestive heart failure, reparatory</b>			<b>2 weeks</b>
DUE TO (c) <b>Arteriosclerotic heart disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Fall in home - 1 wk prior to hospitalization</b>			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>Fell over table top</b>	
20c. TIME OF INJURY Hour Month, Day, Year s.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>Sept 9, 1960</b> to <b>May 14, 1963</b> and last saw him alive on <b>May 14, 1963</b> Death occurred at <b>4:05 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Daniel E. Holmes M.D.</b>		22b. ADDRESS <b>600 S. Glenstone, Springfield</b>	22c. DATE SIGNED <b>May 20 1963</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>MAY 16, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SEYMOUR MASONIC</b>	23d. LOCATION (City, town, or county) (State) <b>WEBSTER CO. MO.</b>
24. FUNERAL DIRECTOR <b>Robert Baeragren, Seymour, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>5-21-63</b>	26. REGISTRAR'S SIGNATURE <b>Effie B. Melton</b>

Daniel E. Holmes, M.D.  
USE BLACK INK  
OR  
TYPEWRITER RIBBON

(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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Manassas 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.