

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38278**

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 1189	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Jackson			
b. CITY (If possible, corporate limits, write RURAL and give township) St Joseph		c. LENGTH OF STAY (in this place) 5 months		c. CITY (If possible, corporate limits, write RURAL and give township) Higginsville - RURAL		d. STREET ADDRESS (If rural, give location) Rural 0540	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital #2							
3. NAME OF DECEASED (Type or Print) Richard Bryan		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 11 14 1953			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH 4-13-1927	
9. AGE (in years, last birthday) 26		10. MONTHS 7		11. BIRTHPLACE (City and State or Foreign Country) Sedalia Mo		12. CITIZEN OF WHAT COUNTRY? America	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mental defective		10b. KIND OF BUSINESS OR INDUSTRY None		13a. FATHER'S NAME Richard Huff Bryan		13b. FATHER'S MAIDEN NAME Attie McFetich	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 712		17. INFORMANT'S SIGNATURE OR NAME B. E. Crossins M.D. State Hosp 2	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Necrosis of the liver ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Spastic paralysis DUE TO (c) Lower limbs are small II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH Chronic since birth since birth	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 351X				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-14 , 19 53 , to 11-14 , 19 53 , that I last saw the deceased alive on 11-14 , 19 53 , and that death occurred at 7:40 p. m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) B. E. Crossins M.D.		23b. ADDRESS State Hospital #2		23c. DATE SIGNED 11-14-1953			
24a. BURIAL, CREMATION, REMOVAL (Specify) Interred		24b. DATE 11/15/1953		24c. NAME OF CEMETERY OR CREMATORY Higginsville, Mo.		24d. LOCATION (City, town, or county) (State) Higginsville, Mo.	
DATE REC'D BY LOCAL REG. Nov 17, 1953		REGISTRAR'S SIGNATURE Ester M. Allison		25. FUNERAL DIRECTOR'S SIGNATURE Heaton-Bauman		ADDRESS St Joseph Mo.	

(Licensed Embalmers' Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed

Eugene Wood

Licensed Embalmer No. 3834

P. O. Address 319 So 10th St, Joseph, 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 this body is not embalmed, fact should be so stated above.