MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

6438

File No.

Registered No. 547

1. PLACE OF DEATH

County Jackson Registration District No. 399

Township Lee Primary Registration District No. 1002

City Kansas City (No. Gen. Hospital No. 2 St. Ward)

2. FULL NAME James Bryant

(a) Residence. No. 544 Cherry St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~ (write the word)
M	Col	Married ~~Widowed~~

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 5, 1870

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Coal Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Ky

PARENTS

10. NAME OF FATHER Joseph Bryant
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ky
12. MAIDEN NAME OF ~~MOTHER~~ Mrs Bryant
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ky

14. INFORMANT Patient's Relative
(Address) All City Hospital

15. FILED 2/6, 1929 W. M. Crouse
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-2 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 9, 1929, to Feb 2, 1929, that I last saw him alive on Feb 2, 1929, and that death occurred, on the date stated above, at 7:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sanitorium
165 | 60 |
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) Senile dementia
(duration) yrs. 3 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory & P
(Signed) H M Smith M. D
2/3, 1929 (Address) Gen Hospt. No 2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Highland
DATE OF BURIAL 2/6 1929

20. UNDERTAKER Hatkins Bros
ADDRESS 1729 Lydia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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