

DEC 15 1938

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

38562  
Do not use this space.

1. PLACE OF DEATH *Boone* 2  
(a) County *Boone* Registration District No. *73*  
(b) Township *Columbia* 1 Primary Registration District No. *3066*  
(c) City *Columbia* (d) Street No. \_\_\_\_\_ St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
2. PRINT FULL NAME *Enoch Bryant*  
(a) Residence, No. *215 Regway ave* St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*  
4. COLOR OR RACE *White*  
5. SINGLE, MARRIED, WIDOWER, OR DIVORCED (write the word) *Married*  
5A. IF MARRIED, WIDOWED, OR DIVORCED - HUSBAND OF (or) WIFE OF *Martha Ann Bryant*  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *1863*  
7. AGE YEARS *75* MONTHS *Not Known* DAYS \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *none*  
9. Industry or business in which work was done, as saw mill, bank, etc. *Pensioner*  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Iowa*  
13. NAME *Samil Bryant*  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Do not know*  
15. MAIDEN NAME *Do not know*  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Do not know*  
17. INFORMANT (ADDRESS) *Mrs George Bartlett  
Columbus Mo*  
18. BURIAL, CREMATION, OR REMOVAL PLACE *Columba* DATE *11-5-38*  
19. FUNERAL DIRECTOR (ADDRESS) *W. A. Vandevanter  
Columbus, MO*  
20. FILED *11/5/* 19 *38* *Allie Selby*  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov 4* 19 *38*  
22. I HEREBY CERTIFY that I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.  
I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at *found dead 6:30 a.m.*  
The principal cause of death and related causes of importance were as follows:  
*Acute Indigestion*  
*Chronic Heart Sufferer*  
Other contributory causes of importance:  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_  
24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_  
(Signed) *M. P. Jacobson* M.D.  
*74* (Address) *Columbus Mo*

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

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.

118

MAR 22 1945

STATEMENT BY LICENSED EMBALMER

I, W. H. Vandewenter, Licensed Embalmer No. 2494

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_ Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed W. H. Vandewenter

Licensed Embalmer No. 2494

**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.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

38562  
Do not use this space.

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1. PLACE OF DEATH

(a) County Boone Registration District No. 73  
(b) Township..... Primary Registration District No. 3006  
(c) City Columbia (d) Street No..... St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Enoch Bryant  
(a) Residence, No. \_\_\_\_\_ St.   
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
75 not known

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_, 19\_\_\_\_

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 4, 1938

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

acute indigestion  
14 years arth. 13 yrs  
Chronic heart disease  
Date of onset

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) W. R. Toalson M. D.

(Address) Columbia Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

