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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
JUL 15 1940  
218

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

21579

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 3015

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Cooper  
(b) City or town Boonville  
(c) Name of hospital or institution: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
In this community Saline Co - Mo 3/4 yrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper  
(c) City or town Nelson Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mary Ann Bryan

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced SINGLE  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 19 - 1936  
(Month) (Day) (Year)

8. AGE: Years 3 Months 8 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Marshall Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Albert L Bryan  
13. Birthplace Nelson Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Melissa Weston  
15. Birthplace Norton Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Albert L Bryan

(b) Address Nelson Mo

17. (a) Burial (b) Date thereof June 20 / 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nelson Mo.

18. (a) Signature of funeral director Woodman Hall  
(b) Address Boonville Mo

19. (a) 6-19-40 (b) D. Hooper  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 19  
year 1940 hour 3:30 minute A. M.

21. I hereby certify that I attended the deceased from June 16, 1940 to June 19, 1940, that I last saw her alive on June 19, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Status - THYMO - LYMPHATICUS

Due to \_\_\_\_\_  
Due to 22

Other conditions Pulmonary Tuberculosis  
(Include pregnancy within 3 months of death)

Major findings: Right Lung  
Of operations \_\_\_\_\_  
Of autopsy As stated above

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature W. H. Ziegler (M. D. or other) M.D.

Address Boonville Mo. Date signed 6-19-40

WRITE PLAINLY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

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RECEIVED  
District Health Officer No. 8  
District File Number  
Date Filed 7-3-40

**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 \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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, above space should be left blank.**