

Registration District No. 875

Primary Registration District No. 3039

Registrar's No. 167

1. PLACE OF DEATH:

(a) County. Vernon  
 (b) City or town. Nevada  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
929 W. Austin  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)  
 In this community 14 yrs

8. (a) PRINT FULL NAME. William Smith Bryan

3. (b) If veteran, name war. no 8. (c) Social Security No. none

4. Sex. M 5. Color or race. W. 6. (a) Single, widowed, married, divorced. Widowed

6. (b) Name of husband or wife. Hannie Bryan 6. (c) Age of husband or wife if alive. \_\_\_\_\_ years

7. Birth date of deceased. Jan 8 1856  
(Month) (Day) (Year)

8. AGE: Years 1 Months 6 Days 5 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation. Retired Publisher

11. Industry or business. Newspaper work

12. Name. Eligal Bryan

13. Birthplace. Uniontown Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name. Mydia Ann McClure

15. Birthplace. Uniontown Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant. Jocann Davis

(b) Address. Nevada, Mo.

17. (a) Cremation (b) Date thereof. July 15 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Kirkwood, Mo.

18. (a) Signature of funeral director. Ferry Funeral Home

(b) Address. Nevada, Mo.

19. (a) 7-14-40 (b) Allen V. Hays  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Mo (b) County. Vernon  
 (c) City or town. Nevada  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 929 W. Austin  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13  
 year 1940 hour 1: minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan 1 - 1938  
 19 \_\_\_\_\_ to July 13 19 40  
 that I last saw him alive on 7/13 19 40  
 and that death occurred on the date and hour stated above.

Immediate cause of death. Cerebral thrombosis  
arterio-sclerosis

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions. \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations. \_\_\_\_\_  
 Of autopsy. no

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 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?  
795  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature. J. M. Hays (M. D. or other) \_\_\_\_\_  
 Address. Nevada, Mo. Date signed. 7/13/40

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

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

08  
2  
2

RECEIVED

District Health Officer No. 7,  
District File Number 8-40-1129  
Date Filed 8-9-40

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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 personally  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Lloyd B. Winsett  
Licensed Embalmer No. 3857  
P. O. Address Merada, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **268-10**

Registration District No. **875-**

Primary Registration District No. **3039**

Registrar's No. ....

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

1. PLACE OF DEATH:

(a) County **Jermon**  
(b) City or town **Jermon**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME **Wm Smith Bryan**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive, \_\_\_\_\_ years

7. Birth date of deceased **Jan 9 1846**  
(Month) (Day) (Year)

8. AGE: Years **94** Months **6** Days **5-** If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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.

20. DATE OF DEATH Month **July** day **13**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?  
\_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

PHYSICIAN CERTIFICATION

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL ENTRY

