

FILLED JUL 19 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22420**

Registration District No. **688**

Primary Registration District No. **4412**

Registrar's No. **15**

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Frankford
(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 1 year 11 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike **82**

(c) City or town Frankford **0**
(If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME John Bryant

3. (b) If veteran, name war: _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race Colord 5. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife: _____ 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased July 8 1939
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27
year 1941 hour 8 minute 9 M.

21. I hereby certify that I attended the deceased from June 26, 1941 to June 27, 1941
that I last saw him alive on June 26, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Complications due auto-intoxication Duration

8. AGE:

Years	Months	Days	If less than one day
<u>1</u>	<u>11</u>	<u>22</u>	_____ hr. _____ min.

9. Birthplace Frankford () Missouri
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Marshel Bryant

13. Birthplace Frankford () Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mary Cambell

15. Birthplace Frankford () Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Bryant

(b) Address Frankford Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29 1941
(Month) (Day) (Year)

(c) Place: burial or cremation Frankford Missouri

18. (a) Signature of funeral director Bull-ton

(b) Address Frankford Missouri

19. (a) July 2-4-41 (b) Mattie Unsee
(Date received at local registrar) (Registrar's signature)

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?
619 (Specify type of place)

While at work? _____ (e) Means of injury 0

23. Signature W. B. ... (M. D. or other) 0

Address Frankford, Mo. Date signed 7/27/41

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

66B

RECEIVED

District Health Officer No. 10

District File Number 1-41-1364

Date Filed JUL 16 1941

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 Dore Fields Negro

Licensed Embalmer No. 40930

P. O. Address Frankford, Pa.

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

State File No. 22420

Registration District No. 688

Primary Registration District No. 4412

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Polk
 (b) City or town Frankford
 (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)

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) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME

John Bryant

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife.....
 alive..... years

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27
 year..... hour..... minute..... M.

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

Immediate cause of death convulsions
dis. auto-intoxication
Enteric colitis

Duration

Due to..... 2

Due to..... 114 W

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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?
 (Specify type of place)
 While at work?..... (e) Means of injury.....

23. Signature Old Bryant (M. D. or other)

Address Frankford, Mo. Date signed.....

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

MOTHER FATHER

SUPPLEMENTARY

S-22420

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.