

Registration District No. **1**

Primary Registration District No. **200**

Registrar's No. **240**

1. PLACE OF DEATH:

(a) County: **Adair**
(b) City or town: **Barton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1, Kirksville R.F.D.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community: **18 months** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Mo.** (b) County: **Adair**
(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

Joseph Walter Bryant

3. (b) If veteran, name with _____

3. (c) Social Security No. _____

4. Sex: **Male** 5. Color or race: **White** 6. (a) Single, married, divorced: **Married**
6. (b) Name of husband or wife: **Ethel Bryant** 6. (c) Age of husband or wife if alive: **54** years
7. Birth date of deceased: **Dec. 26 1879** (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: **Aug** day: **12** year: **1941** hour: **9:30** minute: **0** P.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: **Chronic myocarditis (acute myocardial failure)** Duration _____
Due to _____

Other conditions: **Hypertension** (Include pregnancy within 3 months of death)
Due to _____

Major findings: **930**
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? _____

8. AGE: Years: **64** Months: **7** Days: **14** hr. _____ min. _____

9. Birthplace: **Scotland Co Mo** (City, town, or county) (State or foreign country)

10. Usual occupation: **Farming**

11. Industry or business: _____
12. Name: **Riley Bryant**
13. Birthplace: **Ark** (City, town, or county) (State or foreign country)
14. Maiden name: **Paulina Thurber**
15. Birthplace: **Mo** (City, town, or county) (State or foreign country)

16. (a) Informant: **William H Briggs**
(b) Address: **P.R.#1, Brookside, Iowa**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof: **Aug 14 41** (Month) (Day) (Year)
(c) Place: burial or cremation: **Lawrence Ridge**

18. (a) Signature of funeral director: **Wm. Summers**
(b) Address: **Waverly, Mo**
19. (a) **Aug 13/41** (Date received local registrar) (b) **Spencer L. Nease** (Registrar's signature)

23. Signature: **W.C. Summers** (Specify type of place) (c) Means of injury: _____
Address: **Kirksville, Mo.** Date signed: **8/12/41** (M. D. or other)

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

X28390

RECEIVED

District Health Officer No. 10

District File Number

9-41-1654

Date Filed

SEP 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.....

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, fact should be so stated above.