

FILED JUL 17 1942
399

Registration District No. _____

Primary Registration District No. **1002**

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

1. PLACE OF DEATH: **Jackson**

(a) County **Kansas City**

(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **K.C. General Hospital No. 1** ()
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **6 days**
(Specify whether In this community yours, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **48**

(c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL") **8**

(d) Street No. **3946 Central**
(If rural, give location) **0**

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

3. (a) PRINT FULL NAME **Carrie Bryant**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **3rd**
year **1942** hour **10** m. **55 A.M.** M.

21. I hereby certify that I attended the deceased from **6-28-42**, 19____, to **7-3-42**, 19____;
that I last saw **her** or alive on **7-3-42**, 19____;
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**

6. (b) Name of husband or wife **Will H. Bryant** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **Sept 11 1865**
(Month) (Day) (Year)

Immediate cause of death **Acute basilar thrombus with encephalomalacia**

Due to **83B**

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years **76** Months **9** Days **22** If less than one day hr. ____ min. ____

9. Birthplace **Illinois** (City, town, or county) (State or foreign country) **1**

10. Usual occupation **house wife**

11. Industry or business _____

Major findings: Of operations _____

Of autopsy **See above**

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

MOTHER FATHER { 12. Name **Doace Marshall Parvin**

13. Birthplace **Unknown** (City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Joe T. Riggs**

(b) Address **57 05 - Thompson**

17. (a) **Burial** (b) Date thereof **7-6-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill**

18. (a) Signature of funeral director **P. D. [unclear] & Sons**

(b) Address **3811 Broadway**

19. (a) **7-6-42** (b) **M. H. Brown**
(Date received 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? _____

While at work? _____ (Specify type of place) (e) Means of injury **1**

23. Signature **Diney R. Thom** (M. D. or other) _____
Address **Med. Dir. K.C. Gen. Hospital** Date signed _____

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.....

Leon H. Stewart

Licensed Embalmer No. *4177*

P. O. Address. *Kansas City, 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, fact should be so stated above.