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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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

FILED SEP 2 1943 / 32

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

Primary Registration District No. 3021

Registrar's No. 112

1. PLACE OF DEATH:

(a) County Grundy  
(b) City or town Trenton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Wright Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days Hosp.  
In this community 3 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Wayne  
(c) City or town Rural Cloie  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.F.D.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 2 years.

3. (a) PRINT FULL NAME Bessie Grace Bryan

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Evans Bryan 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased July 21, 1901  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
43 0 7 hr. min.

9. Birthplace Linsville, Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name O. E. Scheson

13. Birthplace Linsville, Iowa  
(City, town, or county) (State or foreign country)

14. Maiden name Grace Henning

15. Birthplace unknown, Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant W. E. Bryan  
(b) Address Cloie, Iowa

17. (a) Burial (b) Date thereof July 30/43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Evergreen Cemetery, Linsville Iowa

18. (a) Signature of funeral director O. A. Arndt  
(b) Address Linsville Iowa

19. (a) 8-6-43 (b) L. D. Roberts  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28<sup>th</sup>  
year 1943 hour 3 minute 59 M.

21. I hereby certify that I attended the deceased from July 27  
1943 to July 28 1943  
that I last saw her alive on July 28 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure

Due to General peritonitis

Due to Purpura appendicis

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

Major findings: General peritonitis  
Of operations: Purpura appendicis  
Of autopsy: None

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 \_\_\_\_\_

23. Signature D. P. Reeks (M. D. or other) \_\_\_\_\_  
Address Trenton Mo Date signed 8/1/43

Duration  
5 hours  
2 days  
3 days  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

110  
2

1530

(Licensed Embalmer's Statement on Reverse Side)

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

Signed

*Ames L. Greenlee*

Licensed Embalmer No.

*3967*

P. O. Address

*Linnville Iowa*

**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.**