DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 21 1946

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 26747-A

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5432

**1. PLACE OF DEATH:**

(a) County: Jackson

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

(c) Name of hospital or institution: General Hospital No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 Day (Specify whether years, months or days)

In this community: 27 years

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No.: 1316 Vine Street, Apt. 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: SAMUEL BRYANT

3. (b) If veteran, name war: no

3. (c) Social Security No. none

4. Sex: Male

5. Color or race: Negro

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife:

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

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

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| About 102 | | | hr. min. |

9. Birthplace: Unknown (City, town, or county) (State or foreign country)

10. Usual occupation: None

11. Industry or business:

FATHER 12. Name: Unknown

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

MOTHER 14. Maiden name: Unknown

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

16. (a) Informant: Medical Records Librarian

(b) Address: General Hospital No. 2

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 9-6-44 (Month) (Day) (Year)

(c) Place: burial or cremation: Anatomical Board (Missouri)

18. (a) Signature of funeral director: Hudson Funeral Home

(b) Address: 35th and Troost

19. (a) 12-31-44 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month: Aug. day: 31 year: 1944 hour: 4 minute: 59 p. M.

21. I hereby certify that I attended the deceased from Aug. 30, 1944, to Aug. 31, 1944 that I last saw him alive on Aug. 31, 1944 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Ca. of Stomach | |
| Due to: With Metastasis Generalized | |
| 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.

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: [illegible] (M. D. or other) M.D.

Address: 600 East 22nd St. Date signed: 12/26/45

(Licensed Embalmer's Statement on Reverse Side)

JAN 23 1946

(b)

## 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 com the above constitutes grounds for revocation of license.)**

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