

S. No. 2
DM-5-43
v. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *23413*

FILED JUL 17 1945

Registration District No. *8*

Primary Registration District No. *3006*

Registrar's No. *158*

1. PLACE OF DEATH:

(a) County *Boone*

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

(c) Name of hospital or institution: *Route 6*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *79 Years*
(Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Boone*

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

(d) Street No. *Route 6*
(If rural, give location)

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

3. (a) PRINT FULL NAME *THOMAS JEFFERSON BRYSON*

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* day *4* year *1945* hour *8* minute *P* M.

21. I hereby certify that I attended the deceased from *4-6-45* to *6-4-45* and that death occurred on the date and hour stated above

4. Sex *Male* 5. Color or race *White*

6. (a) Single, widowed, married, divorced *Married*

6. (b) Name of husband or wife *Carrie Craig Bryson*

6. (c) Age of husband or wife if alive *1866* years

7. Birth date of deceased *5-20-1866*
(Month) (Day) (Year)

Immediate cause of death *Myocardial Infarction* Duration *Small*

Due to *Age 93*

8. AGE: Years *79* Months *0* Days *14*
If less than one day _____ hr. _____ min.

Other conditions *None*
(Include pregnancy within 3 months of death)

Major findings: *None*

Of operations _____

Of autopsy *None*

9. Birthplace *Boone County Missouri*
(City, town, or county) (State or foreign country)

10. Usual occupation *Farmer*

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name *Soloman Bryson*

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

14. Maiden name *Mary Rippeto*

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

16. (a) Informant *Thomas Bryson Jr.*

(b) Address *Columbia, Mo.*

17. (a) *Burial* (b) Date thereof *6-6-45*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Memorial Park Cemetery*

18. (a) Signature of funeral director *Barber Funeral Service*

(b) Address *Columbia, Mo.*

19. (a) *6-6-45* (b) *Edna H. Barber*
(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) *No*

(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? *No* (Specify type of place) _____

(c) Means of injury _____

23. Signature *J. P. [unclear]* (M. D. or other) _____

Address *Columbia, Mo.* Date signed *6-6-45*

1250 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 7-16-45

JUL 19 1945

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 Charles L. Lang

Licensed Embalmer No. 4132

P. O. Address Columbia, 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.