

S. No. 2
M-5-43
7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 21 1945
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **38976**
Registrar's No. **10764**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: 1 Hr. 20 Mins
(Specify whether
In this community 44 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo. (b) County.....
(c) City or town..... St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1920 Mallincrodt St
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Frank H Bryan

3. (b) If veteran, name war..... no
3. (c) Social Security No. 490-09-6928

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife..... Elsie Bryan
6. (c) Age of husband or wife if alive 34 years
7. Birth date of deceased..... 10 7 1904
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|----------|----------------------|
| <u>41</u> | <u>2</u> | <u>1</u> | hr. min. |

9. Birthplace Chamois Mo. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Com Laborer

11. Industry or business.....

MOTHER FATHER

12. Name William Bryan

13. Birthplace Chamois Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Emalia Bloomer

15. Birthplace Chamois Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elsie Bryan

(b) Address 1920 Mallincrodt St

17. (a) Burial (b) Date thereof 12-11-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director Goodhart & Goodhart

(b) Address 2228 St. Louis Ave

19. (a) DEC 11 1945 (b) J. F. Brundage
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 8
year 1945 hour 3 minute 20p M.

21. I hereby certify that I attended the deceased from out. 1. 1945 to Dec 8. 1945
that I last saw h alive on Dec. 5
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations.....
Of autopsy.....
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?

While at work? (Specify type of place) (c) Means of injury.....

23. Signature J. F. Brundage (M. D. or other)
Address 4503 Washington Date signed 12/10/45

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

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 *Marie A. Cashion*

Licensed Embalmer No. *3949*

P. O. Address *St. Louis 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.