

S. No. 2  
M-5-43  
7-17-39  
X-28671

**FILED** SEP 10 1946  
Registration District No. **164**

Primary Registration District No. **3032**

Registrar's No. **76**

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

1. PLACE OF DEATH:

(a) County **Johnson**

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

(c) Name of hospital or institution:  
**414 East Broad** /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **None**  
(Specify whether years, months or days)

In this community **9 years**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Johnson** **51**

(c) City or town **Warrensburg**,  
(If outside city or town limits, write "RURAL") **2**

(d) Street No. **414 East Broad** **2**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No) **1**  
If yes, name country

3. (a) PRINT FULL NAME **Sarah Sewall Bryant**

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **19**  
year **1946** hour **8:** minute **00** a. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 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 **Powhatten Bryant**

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

7. Birth date of deceased **January 9 1867**  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_

Due to **# Natural causes**

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Includes pregnancy, etc.)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<b>79</b>	<b>7</b>	<b>1</b>	hr. _____ min.

9. Birthplace **Jackson Alabama**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **None stated**

12. Name **Lewis Sewall**

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

14. Maiden name **Amelia Ann DuBose**  
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Mrs Howard Bryant**

(b) Address **Warrensburg, Missouri**

17. (a) **Burial** (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Masonic Cemetery**

18. (a) Signature of funeral director **M. J. Miller**  
**Warrensburg, Missouri**

(b) Address **Warrensburg, Missouri**

19. **Aug. 21-46** **Sarah Sewall Bryant**  
(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 **3**

23. Signature **F. May Andrews** **Coroner**  
**Field Holden** **Mo.** (Date signed) **Aug. 20**

**ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED**  
**200 A**

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

147

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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: .....

Licensed Embalmer No. 4059.....

P. O. Address Holden, 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.

Registration District No. 164 Primary Registration District No. 3032

1. PLACE OF DEATH:

(a) County Johnson

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

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

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Sarah S. Bryant

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Jan (Month) 15 (Day) 1899 (Year)

8. AGE: Years 79 Months 7 Days \_\_\_\_\_ (If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Year 1946 hour 10 minute 19 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death She had suffered  
some two or three "strokes"  
over a period of years,  
due to  
hypertension, I thought it was  
congestive heart failure  
due to  
leading Christian Science 2 yrs.  
she never complained to her  
family. Somewhat of a stroke  
(Includes pregnancy within 3 months of death)  
A Physician had been called  
Major findings before I reached PHYSICIAN  
Of operation there, his diagnosis was  
Of autopsy Natural Causes (Cause of which death should be charged statistically.)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 200 A

(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 Mrs. F. May Andrews, Coroner (M. D. or other)  
Address Holdaway, Mo. Date signed Oct 3/46

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

26391

SUPPLEMENTARY

27652