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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34977

State File No. _____

FILED NOV 12 1946

Registration District No. **318**

Primary Registration District No. _____

Registrar's No. **9308**

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital—Max C. Starkloff
(If not in hospital or institution, write street number or location)

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000

(c) City or town ST. LOUIS 1017
(If outside city or town limits, write "RURAL")

(d) Street No. 4136 Lexington Memorial 9
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME CHARLES BRYAN

3. (b) If veteran, name war WORLD WAR #1

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife MARGARET BRYAN

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased FEB 16TH 1885
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 30th
year 1946 hour 7:30 minute A M.

21. I hereby certify that I attended the deceased from 10/25/46
_____ 19, to Oct. 30th 1946
_____ 19, to Oct. 30th 1946

that I last saw him alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrum & the rest of Duration _____

Due to _____

Due to _____

Other conditions: He
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

58 8 14 hr. _____ min.

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

10. Usual occupation Nil

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name JOSEPH BRYAN 7

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

14. Maiden name NETTIE UNKNOWN (City, town, or county) (State or foreign country)

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

16. (a) Informant MARGARET BRYAN 1

(b) Address 4136 LEXINGTON

17. (a) BURIAL (b) Date thereof 11/1/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NATIONAL CEM. O.B. MO.

18. (a) Signature of funeral director WILLIAM FUNERAL DIR

(b) Address 2849 S. Euclid

19. (a) OCT 31 1946 (Date received local registrar)

J. F. Bredbeck (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? Dr. Home 0
(Specify type of place) Means of injury

23. Signature 1515 Lafayette 10/30/46 (M.D. or other) 0

Address _____ Date signed _____

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 *Robert L. Brinkman*

Licensed Embalmer No. *3553*

P. O. Address.....

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.