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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 31 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40487
Registrar's No. 5279

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County WATSON

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

(c) Name of hospital or institution:
1515 PARK ST
(If not in hospital or institution, write street number or location)

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

In this community 3 MONTHS
years, months or days

3. (a) PRINT FULL NAME MARIE LOUISE BRYANT

3. (b) If veteran, name war NO

3. (c) Social Security No. none

4. Sex FEMALE 5. Color or race W. BRN.

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug. 29, '46
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
	<u>3</u>	<u>12</u>	<u>13</u> hr. (min.)

9. Birthplace TANIAS CITY, MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business _____

MOTHER { 12. Name X 9

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

14. Maiden name Celestie Bryant

15. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

FATHER { 16. (a) Informant E. Nestine Allen

(b) Address 1515 PARK AVE.

17. (a) BURIAL (b) Date thereof Dec. 17, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cem.

18. (a) Signature of funeral director G. G. ...

(b) Address 1513 ... AVE.

19. (a) 12-17-46 (b) Geraldine Helmer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County WATSON

(c) City or town TANIAS CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 1515 PARK AVE.
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 12
year 1946 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from 19 to 19
Deputy-Coroner
that I last saw the deceased alive on 19
and that death occurred on the date and hour stated above.

Immediate cause of death Suffocation

Due to Same as above

Due to Suffocation in bed while asleep.

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 182-8
19

Of operations _____

Of autopsy no-Permit

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

(a) Accident, suicide, or homicide (specify) Accident 123

(b) Date of occurrence 12-12-46

(c) Where did injury occur? N. C. Gaultner - Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home - 1515 - Park

While at work? Sleep (Specify type of place)

(e) Means of injury Suffocation

23. Signature Thurcellianus (M. D. or other) D. E.

Address 2636 - Brooklyn Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

12-14-46

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 ~~W. C. Davis~~ *W. C. Davis*
Licensed Embalmer No. *4417*
P. O. Address *W. C. Davis*

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.