

No. 2  
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FILED JAN 9 1948

Registration District No. 174

Primary Registration District No. 3035

Registrar's No. 80

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

1. PLACE OF DEATH:

(a) County Lafayette

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

(c) Name of hospital or institution:  
523rd St  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 yrs (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME MARTHA J Bryant

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Fe / 5. Color or race W

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

6. (b) Name of husband or wife Atlas P. Bryant

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

7. Birth date of deceased Nov 13 - 1856  
(Month) (Day) (Year)

8. AGE: Years 89 Months 11 Days 18 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation at home

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

12. Name Larry D Short

13. Birthplace Not known  
(City, town, or county) (State or foreign country)

14. Maiden name Willie Claxton

15. Birthplace Not known  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs E. A. Weston

(b) Address Livingston Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-47  
(Month) (Day) (Year)

(c) Place: burial or cremation Ligginsville Mo

18. (a) Signature of funeral director Wm J Stump

(b) Address Livingston Mo

19. (a) 12-3-47 (Date received local registrar) (b) Minimal Eastburn (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette

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

(d) Street No. 523 St  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 1 year 1947 hour 7 minute 20 A.M.

21. I hereby certify that I attended the deceased from Oct 20, 1947, to Nov 1, 1947

that I last saw her alive on Nov 1, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia

Due to Fracture hip & old age

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 8 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy St 10

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 \_\_\_\_\_

23. Signature Ben H. Broder (M. D. or other) \_\_\_\_\_

Address Livingston Mo Date signed 11/1/47

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 1-8-48

*B. B. B.*

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 *L. W. Keene*

Licensed Embalmer No. 2983

P. O. Address *Lebanon, 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. 174 Primary Registration District No. 3031

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Lexington  
(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  
years, months or days)

In this community \_\_\_\_\_  
years, months or days

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Martha J. Bryant

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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 \_\_\_\_\_

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 alive \_\_\_\_\_

7. Birth date of deceased Nov-13  
(Month) (Day) (Year)

8. AGE: Years 89 Months 1 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

MOTHER FATHER

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

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

14. Maiden name \_\_\_\_\_

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)

Duration \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_

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) Fall in Home ✓

(b) Date of occurrence Oct 27 - 1947

(c) Where did injury occur? Home Lexington MO  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Farm

While at work? no (Specify type of place) (e) Means of injury Fall over rug

23. Signature Ben H. B... (M. D. or other)  
Address Lexington Mo Date signed 1-13-48

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

SUPPLEMENTARY

42174