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FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9860
2569

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Peoples Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 4867 Fountain Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Effie
b. (Middle): S.
c. (Last): Bryant

4. DATE OF DEATH (Month) (Day) (Year): 3/20/49

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 10/22/84
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Liberty, Missouri
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: French Stewart
13b. MOTHER'S MAIDEN NAME: Maggie Wilson
14. NAME OF HUSBAND OR WIFE: Leon P. Bryant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Leon P. Bryant, 4867 Fountain Ave.
ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension 830
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 331X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): NO
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-9-, 1949, *to* 3-20, 1949, *that I last saw the deceased alive on* 3-19-, 1949, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Dan M. Carter, M.D. (Degree or title)
23b. ADDRESS 2425 Biddle. STL. Mo
23c. DATE SIGNED 3/22/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 3/23/49
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): Kansas City, Missouri

DATE REC'D BY REGISTRAR: MAR 2 2 1949
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Chas. J. Gates, 4107 Finney Avenue

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 .....

....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed John K Cunningham

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Av

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.