

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25996

State File No. ....

FILED JUL 20 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 189

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>	c. LENGTH OF STAY (In this place) <u>5 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>O'Fallon</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		d. STREET ADDRESS (If rural, give location) -----	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Rose</u>	b. (Middle) <u>E.</u>	c. (Last) <u>Bryan</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 4 1953</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>March 31 1882</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 28 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>O'Fallon Rural Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USH</u>
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13a. FATHER'S NAME <u>Patric Bryan</u>	13b. MOTHER'S MAIDEN NAME <u>Hanneberry</u>	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Tom Bryan</u>	ADDRESS <u>O'Fallon Mo.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>? 1 yr</u> <u>? 9 mo</u> <u>?</u> <u>?</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of gall bladder</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Metastatic carcinoma of liver</u> DUE TO (c) <u>Cholelithiasis 155x</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>cholecystitis chronic</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of gall bladder + simple gall stones</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	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) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 2, 1953, to July 4, 1953, that I last saw the deceased alive on July 4, 1953, and that death occurred at 11:40 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Russell Hider M.D.</u>	23b. ADDRESS <u>St Charles, Mo.</u>	23c. DATE SIGNED <u>7-6-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7-8-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception</u>	24d. LOCATION (City, town, or county) (State) <u>Dardenne Mo</u>
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DATE REC'D BY LOCAL REG. <u>July 16-53</u>	REGISTRAR'S SIGNATURE <u>Fannie Hamilton</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>E. K. Kelly</u>	ADDRESS <u>O'Fallon Mo.</u>
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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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*E. Keithly*

Signed.....  
Student Embalmer.....

Licensed Embalmer No..... *875*

P. O. Address..... *Dallow M*

**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.