

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **2628**  
Registrar's No. **0794**

FILED FEB 2 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis</b>	
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS (If rural, give location) <b>4309 Easton Ave.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Peoples Hospital</b>		2119/0	

<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>Buster</b> b. (Middle) _____ c. (Last) <b>Bryant</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>1 21 54</b>		
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Colored</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Single</b>	
<b>8. DATE OF BIRTH</b> <b>May 1, 1919</b>		<b>9. AGE</b> (In years last birthday) <b>34</b>		IF UNDER 1 YEAR: Months _____ Days _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>City Dept.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Augusta Ark.</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>					

<b>13a. FATHER'S NAME</b> <b>Jack Bryant</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Bobie Mullen</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>None</b>	
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War #2</b>		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <b>Mrs Bobie Bryant 2810 Delmar Blvd.</b>	
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>Acute Bronchopneumonia</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>24 hrs</b>	
<b>ANCECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		<b>DUE TO (b)</b> <b>Herniation gastric mucosa</b>		<b>8 mos</b>	
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.		<b>DUE TO (c)</b> _____			

<b>19a. DATE OF OPERATION</b> <b>1-21-54</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>Herniation gastric mucosa obstruction</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) _____		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> <b>5615</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____		<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> _____	

**22. I hereby certify that I attended the deceased from Dec. 10, 1953 to Jan. 21, 1954, that I last saw the deceased alive on 1-21-54, and that death occurred at 3 P. M., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> (Degree or title) <b>D. J. Verda M.D.</b>		<b>23b. ADDRESS</b> <b>4500 Olive St</b>		<b>23c. DATE SIGNED</b> <b>1-25-54</b>	
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24b. DATE</b> <b>1-28-54</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>National Cemetery</b>	
				<b>24d. LOCATION</b> (City, town, or county) (State) <b>Jefferson Barracks Missouri</b>	

<b>DATE REC'D BY LOCAL REG.</b> <b>JAN 26 1954</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Carl Smith MD</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>Ellis Funeral Home Inc. 2820 Stoddard St.</b>	
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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed James R. Carter

Licensed Embalmer No. # 681

P. O. Address St. Louis, 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.