FILED FEB 25 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

6051

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1078

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis, Mo. Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Firmin Desloge Length of stay in 1b 12 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Montana b. COUNTY
c. CITY OR TOWN Billings 8250 Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 545 Avenue East Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Robert Middle Lee Last Bryan

4. DATE OF DEATH Month February Day 2 Year 1957

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Dec.25,1936

9. AGE (In years last birthday) 20 IF UNDER 1 YEAR Months 1 Days 7 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) College Student

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Columbus, Montana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME G.Frank Bryan

14. MOTHER'S MAIDEN NAME Vera Alice Griffith

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 Mrs.Vera Alice Bryan. Address 545 Avenue East Billings, Mont.

MEDICAL CERTIFICATION

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

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor

INTERVAL BETWEEN ONSET AND DEATH 6 ms ±

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 193+

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1/23/57 to 2/2/57 and last saw her/him alive on 2/2/57
Death occurred at 5.30 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. A. Smolek Mo

22b. ADDRESS Beaumont Med Bldg

22c. DATE SIGNED 2/3/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE Feb. 3, 57.

23c. NAME OF CEMETERY OR CREMATORY Billings

23d. LOCATION (City, town, or county) (State) Billings, Montana

24. FUNERAL DIRECTOR ADDRESS Arthur J. Donnelly 3840 Lindell Blvd.

25. DATE RECD. BY LOCAL REG. FEB 4 '57

26. REGISTRAR'S SIGNATURE Carl Smith MD MSB.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Queried - Tumor as malignant

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, ~~or by~~ ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 46

P. O. Address 3840 E

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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