

Health, Welfare, Public Service

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FILED FEB 18 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-006256

STATE FILE NUMBER

Registration District No. 170

Primary Registration District No. 3033

Registrar's No. 19

1. PLACE OF DEATH a. COUNTY Laclede			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Laclede		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lebanon		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Eldridge		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Wallace Hospital		Length of stay in lb 7 Days	d. STREET ADDRESS (If outside, give location) Eldridge		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) GEORGE DEWEY BRYANT			4. DATE OF DEATH Month Feb. Day 8, Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1900	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (City and state or country) Butler, Tenn.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Robert A. Bryant		13b. MOTHER'S MAIDEN NAME Neoma Ward		14. NAME OF HUSBAND OR WIFE Alberta Bryant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None.	17. INFORMANT Address Belle Bryant Eldridge, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia, lobar,					INTERVAL BETWEEN ONSET AND DEATH 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Cardiac decompensation					10 days
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic bronchial asthma					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 490X		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 Feb 2, 1958 , to Feb 8, 1958 and last saw him alive on Feb 8, 1958 Death occurred at 9:00P m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) James L. Hope, M.D.			22b. ADDRESS Lebanon, Mo		22c. DATE SIGNED 5/11/58
23a. BURIAL CREMATION, REMOVAL, (Specify) Burial		23b. DATE 2/13/58	23c. NAME OF CEMETERY OR CREMATORY Lebanon City Cemetery		23d. LOCATION (City, town, or county) (State) Lebanon, Mo.
24. FUNERAL DIRECTOR S. R. Palms			ADDRESS Lebanon mo. 2-13-1958	25. DATE RECD. BY LOCAL REG. 5/11/58	
26. REGISTRAR'S SIGNATURE Hella L. Gray					

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms or signs of disease. All diseases in Part I must be causally related.

Received FEB 17 1958
Laclede County Health Unit
File No. 19
Date Filed FEB 17 1958

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,
Signature of Student Embalmer

Signed S. P. Palmer

Licensed Embalmer No. 2208
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.