

Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019339  
STATE FILE NUMBER

FILED MAY 29 1958

Registration District No. 296 Primary Registration District No. 6018 Registrar's No. 14

S. 300  
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Ray</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fishing River</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Excelsior Springs</u> <u>6890</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RFD. 2</u>			Length of stay in 1b <u>Lifetime</u>		d. STREET ADDRESS <u>RR#2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Belle</u> Last <u>Bryant</u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1958</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 2, 1900</u> <u>57</u>		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Camden, Missouri</u> <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>William Sloan</u>			13b. MOTHER'S MAIDEN NAME <u>Fannie Albertson</u>			14. NAME OF HUSBAND OR WIFE <u>Lee F. Bryant</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT Address <u>Mr. Lee F. Bryant, Excelsior Springs, Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sev. min.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary insufficiency</u>						<u>sev. mos.</u>		
DUE TO (c) <u>4201</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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.)					
20c. TIME OF INJURY Hour <u>12:30</u> Month <u>5</u> Day <u>23</u> Year <u>1958</u> a.m. <u>A.M.</u> 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 <u>5/23/58</u> to <u>5/23/58</u> and last saw <u>him</u> alive on <u>XXXXXXXXXXXXXX</u> Death occurred at <u>12:30 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>M. D. Crisken</u> (Degree or title) <u>M. D.</u>				22b. ADDRESS <u>Excelsior Springs, Mo.</u>		22c. DATE SIGNED <u>5/23/58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-26-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Missouri City</u>		23d. LOCATION (City, town, or county) (State) <u>Missouri City, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>5-26-58</u>		26. REGISTRAR'S SIGNATURE <u>Helen J. Laska</u>		

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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 *Ralph L. Loughran*

Licensed Embalmer No. *4009*  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.