

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029530

FILED VS AUG 28 1959

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 162

STATE FILE NUMBER

IDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Jasper</u>		b. CITY (If outside Corporate limits, give TOWNSHIP only) OR TOWN <u>Carthage</u>		Length of stay in 1b <u>67 yrs.</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McCune Brooks Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Carthage</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
				d. STREET ADDRESS (If outside, give location) <u>1249 S. Maple</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>George</u>		Middle <u>Gregory</u>		Last <u>Bryan</u>		Month <u>August</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Male</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>1-10-81</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Colesburg, Ky.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>W.F. Bryan</u>			13b. MOTHER'S MAIDEN NAME <u>Clarissa Spink</u>			14. NAME OF HUSBAND OR WIFE <u>Nellie James Bryan</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>None</u>		17. INFORMANT <u>James F. Bryan & Carthage, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Perforating gunshot wound of cranium and brain</u>						<u>3 hours</u>	
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)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Accidental discharge of rifle when shooting rats</u>					
20c. TIME OF INJURY <u>2:30</u>	Hour _____ a.m. _____ p.m.	Month, Day, Year <u>8/17/59</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Alley in town</u>		20f. CITY, TOWN, OR LOCATION <u>Carthage</u>		COUNTY <u>Jasper</u> STATE <u>Missouri</u>	
21. I attended the deceased from <u>8/17/59</u> to <u>8/17/59</u> and last saw ^{her} him alive on <u>8-17-59</u>				Death occurred at <u>5:25 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Charles H. Scheel</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>Carthage, Missouri</u>		22c. DATE SIGNED <u>8-18-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-20-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Park</u>		23d. LOCATION (City, town, or county) <u>Carthage, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>The Ulmer Funeral Home-Carthage, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>8-19-59</u>		26. REGISTRAR'S SIGNATURE <u>Ely Clinton</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Edwin S. May*

Licensed Embalmer No. 4955

P. O. Address *Portage*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.