

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-004544

FILED VS FEB 1 1960 317

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 666

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death.) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis Co.</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy, Mo.</u>		Length of stay in 1b <u>1 DAY</u>	c. CITY OR TOWN <u>St. Louis, Missouri</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>Normandy Hotel</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>764 DALLAS DR.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Gregory</u> Last <u>Bryant</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1/5/60</u>	9. AGE (last birthday) <u>N.B.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James H. Bryant</u>		13b. MOTHER'S MAIDEN NAME <u>Barbara L. Erker</u>		14. NAME OF HUSBAND OR WIFE <u>-</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Barbara Bryant</u>			Address
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>Heart failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hr</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive heart failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u>	
DUE TO (c) <u>St. Louis Venereal Disease Center</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Birth</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) <u>Congestive heart failure</u>					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 checked="" type="checkbox"/> NO <input 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>-</u> Month, Day, Year <u>-</u>						
20d. INJURY OCCURRED WHILE AT WORK <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>1-5-60</u> to <u>1-6-60</u> and last saw her/him alive on <u>1-6-60</u> Death occurred at <u>9:25 PM.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>James H. Bryant</u> (Degree or title)		22b. ADDRESS <u>3707 Ashby Rd.</u>		22c. DATE SIGNED <u>1-6-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>Jan 8, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Trinity Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>			
24. FUNERAL DIRECTOR <u>Beiderwieden F.H., Inc., 1936 St. Louis Av.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1-8-60</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</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 _____
Homer W. [Signature]

Licensed Embalmer No. 3882

P. O. Address St. Louis

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.