

FILED VS DEC 21 1960

Registration District No. 237 Primary Registration District No. _____ Registrar's No. 90

STATE FILE NUMBER

7. PLACE OF DEATH a. COUNTY <u>Shelby</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Shelby</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Black Creek Township</u>		Length of stay in 1b <u>1 Mo</u>	c. CITY OR TOWN <u>Shelbina</u>
c. FULL NAME OF (If NOT in hospital, give location) <u>Pleasant Hill Rest Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Harriet</u> Middle <u>Bessie</u> Last <u>Elizabeth Bryan</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>9th</u> Year <u>1960</u>			
5. SEX <u>Female</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>9/15/1869</u>	9. AGE (last birthday) <u>91</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>24</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>		11. BIRTHPLACE (City and state or country) <u>Monroe Co Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>Joseph H Bryan</u>			13b. MOTHER'S MAIDEN NAME <u>Lucy K Acuff</u>		14. NAME OF HUSBAND OR WIFE <u>Catherine Hollenbeck Shelbina Mo</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>No</u>		17. INFORMANT <u>Catherine Hollenbeck Shelbina Mo</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>Acute congestive heart failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sept 9</u> <u>Jan 1955 - 1960</u>
DUE TO (b) <u>Chronic congestive heart failure arteriosclerosis</u>			
DUE TO (c) <u>Seizure premature ventricular contractions</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic arteriosclerosis of right heart anterior portion of left femur.</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.) <u></u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY _____ STATE _____
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21. I attended the deceased from <u>Jan 20 1955</u> to <u>Dec 4, 1960</u> and last saw her alive on <u>Dec 4, 1960</u> Death occurred at <u>Dec 9, 1960 1 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Madge Bowen DO</u>	22b. ADDRESS <u>Shelbina Mo</u>	22c. DATE SIGNED <u>Dec 12, 1960</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/12/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakridge Cemetery</u>	23d. LOCATION (City, town, or county) <u>5 Miles So Lenter</u>	(State) <u>Mo</u>
24. FUNERAL DIRECTOR <u>Barkelaw & Davis</u>		ADDRESS <u>Shelbina Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-15-60</u>	26. REGISTRAR'S SIGNATURE <u>Ada Garrison</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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Devery A. Baskelard

Licensed Embalmer No. 3835

P. O. Address Shelburne Vt

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.