

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035206

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2549

STATE FILE NUMBER

FILED SEP 29 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, Mo.</u>		Length of stay in lb <u>123 days</u>	c. CITY OR TOWN <u>St. Louis, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R. Koch Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2340 Park</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ulysses</u> Middle <u>Bryant</u> Last <u>Bryant</u>			4. DATE OF DEATH Month <u>9</u> Day <u>8</u> Year <u>61</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-92</u> 9. AGE (last birthday) <u>69</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Kentucky</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Beryl</u>		13b. MOTHER'S MAIDEN NAME <u>Laura</u>	14. NAME OF HUSBAND OR WIFE <u>Thelma Bryant, dec.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW1 49410-6857</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>	17. INFORMANT Address <u>Elizabeth Madden, 1660 S. Jefferson</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>Bacterial Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>DUE TO (b) Chronic Pulmonary Tuberculosis</u> <u>DUE TO (c) Cardiac Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1w.</u> <u>12 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>493XA</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 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>6.15</u> a.m. p.m. Month, Day, Year <u>9-8-61</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.)	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u> COUNTY <u>St. Louis</u> STATE <u>Mo.</u>
21. I attended the deceased from <u>9-8-61 6.15 P.M.</u> to <u>9-8-61</u> and last saw her/him alive on <u>9-8-61</u> Death occurred at <u>6.15 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Bernard Fuerman, M.D.</u>		22b. ADDRESS <u>R. Koch Hospital</u>	22c. DATE SIGNED <u>9-8-61</u> (State)
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>BURIAL</u>	23b. DATE <u>9/11/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>	23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>McLAUGHLIN'S, 2301 Lafayette</u>		25. DATE RECD. BY LOCAL REG. <u>9-11-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>

STATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

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 A. G. Jarvis

Licensed Embalmer No. 3384

P. O. Address A. Jarvis

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.