

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036020

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4933

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

<p style="font-size: 18pt; font-weight: bold;">FILED SEP 23 1963</p> <p>1. PLACE OF DEATH</p> <p>a. COUNTY Jackson</p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in 1b 20 years</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE Missouri b. COUNTY Jackson</p> <p>c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) 4800 East 6th Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) First Lottie Middle Mae Last Bryant</p>			<p>4. DATE OF DEATH Month September Day 6th Year 1963</p>		
<p>5. SEX Female</p>		<p>6. COLOR OR RACE White</p>		<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH 7-21-1888</p>		<p>9. AGE (last birthday) 75</p>		<p>IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>			<p>10b. KIND OF BUSINESS OR INDUSTRY Home</p>		<p>11. BIRTHPLACE (City and state or country) Independence, Mo.</p>
<p>12. CITIZEN OF WHAT COUNTRY USA</p>					
<p>13a. FATHER'S NAME John Smith</p>			<p>13b. MOTHER'S MAIDEN NAME Unknown</p>		<p>14. NAME OF HUSBAND OR WIFE Eugene P. Bryant</p>
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No</p>			<p>16. SOCIAL SECURITY NO. [REDACTED]</p>		<p>17. INFORMANT Address Eugenia Zaman 4800 E 6th KC, Mo.</p>
<p>18. CAUSE OF DEATH (Enter only one cause per line)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) Coronary Arterial Atherosclerosis</p> <p style="text-align: center;">DUE TO (b) Generalized Atherosclerosis</p> <p style="text-align: center;">DUE TO (c) _____</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>					
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>				<p>PART III. If deceased was female was there a pregnancy in last 90 days.</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
		<p>20f. CITY, TOWN, OR LOCATION</p>		<p>COUNTY STATE</p>	
<p>21. I attended the deceased from Aug 30, 1963 to Sept 6, 1963 and last saw her alive on 9/6/63</p> <p>Death occurred at 10:57 A m on the date stated above, and to the best of my knowledge, from the causes stated.</p>					
<p>22a. SIGNATURE (Degree or title) M. Friedman M.D.</p>			<p>22b. ADDRESS 201 E. 63 K.C. Mo.</p>		<p>22c. DATE SIGNED 9/7/63</p>
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE 9-9-1963</p>	<p>23c. NAME OF CEMETERY OR CREMATORY Floral Hills</p>		<p>23d. LOCATION (City, town, or county) Kansas City, Missouri</p>
<p>24. FUNERAL DIRECTOR ADDRESS Floral Hills Funeral Home Kansas City, Mo.</p>			<p>25. DATE RECD. BY LOCAL REG. 9-9-63</p>		<p>26. REGISTRAR'S SIGNATURE Bessie Smith</p>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DATE AMENDED

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

Friedman

VS 300 Rev. 4/59

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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 *E. M. Joiner*
Licensed Embalmer No. 3453

P. O. Address H. E. Han

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.

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