LOCAL REGISTRAR'S RECORD

17167

JUL P3 1929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County: Barry

Township or Village: Flatcreek / Cassville

Registration District No. 29 | File No. ...

Primary Registration District No. 4021 | Registered No. 33

City ... (NO. ... St.; ... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME: Elizabeth E Bryant

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX: Fe	4 COLOR OR RACE: Wh	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married
6 DATE OF BIRTH: May (Month) 6 (Day), 1857 (Year)		
7 AGE: 71 yrs. 11 mos. 29 ds.	If LESS than 1 day, ...hrs. or ...min.?	
8 OCCUPATION (a) Trade, profession, or particular kind of work: Housewife		
(b) General nature of industry, business, or establishment in which employed (or employer):		
9 BIRTHPLACE (City or town, State or foreign country): Barry Co Mo		
PARENTS 10 NAME OF FATHER: Everhart Hadley		
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Tenn		
12 MAIDEN NAME OF MOTHER:		
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country):		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Willie Bryant

(Address) Monett Mo

15 Filed July 1, 1929 Mrs H. R. Williams Dpt. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 8 (Day), 1928 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb, 1928, to date of death, 1928, that I last saw her alive on May 3, 1928, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Colitis with possibly ulcer of stomach

History of 8 or 10 years (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) W. A. Chandler M.D.

May 6, 1928 (Address) Cassville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL: Oak Hill | DATE OF BURIAL: 5-6, 1928

20 UNDERTAKER: Horine Funeral Service | ADDRESS: Cassville Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County ....

Township .... Registration District No. .... File No. ....
or
Village .... Primary Registration District No. .... Registered No. ....
or
City .... (NO. ...., ... St.; .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME ....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH .... (Month) (Day), 1.... (Year)

7 AGE .... yrs. .... mos. .... ds. — If LESS than 1 day, ... hrs. or ...... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry business or establishment in which employed (or employer) ....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ....

(Address) ....

15

Filed .... , 191 ...., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH .... (Month) (Day), 191 .... (Year)

17 I HEREBY CERTIFY, that I attended deceased from .... , 191 ...., to .... , 191 ....,

that I last saw h.... alive on .... , 191 ....,

and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH* was as follows:

....

....

....

.... (Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) ....

.... (Duration) .... yrs. .... mos. .... ds.

(Signed) .... M. D.

.... , 191 .... (Address) ....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ...... yrs. ...... mos. ...... ds. In the State ...... yrs. ...... mos. ...... ds.

Where was disease contracted if not at place of death? ....

Former or usual residence ....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL .... , 191 ....

20 UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH

County Barry Registration District No. 29 File No.

Township Primary Registration District No. 4021 Registered No. 33

City Cassville (No. St. Ward)

2. FULL NAME Elizabeth E. Bryant

(a) Residence. No. St., Ward. (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ......min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT (Address)

15. FILED Dec. 19 29 Mrs. W. R. Williams Dpt. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 5 1929

17. I HEREBY CERTIFY, That I attended deceased from ......, 19.... to ......, 19...., that I last saw h.... alive on ......, 19...., and that death occurred, on the date stated above, at ......m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) ......yrs. ......mos. ......ds.

CONTRIBUTORY (SECONDARY)

(duration) ......yrs. ......mos. ......ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? ...... DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) ......, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

S-17167