

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **5586**

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Mos. 21 Days
(Specify whether
In this community 37 yrs.
years, months or days)

3. (a) PRINT FULL NAME Jacob Byers **620**

3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased January 3, 1872
(Month) (Day) (Year)

8. AGE: Years 68 Months 5 Days 18 If less than one day hr. min.

9. Birthplace Penna.
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Unknown

12. Name Peter Byers

13. Birthplace Penna.
(City, town, or county) (State or foreign country)

14. Maiden name Lydia (Unknown)

15. Birthplace Penna.
(City, town, or county) (State or foreign country)

16. (a) Informant A. Morrison

(b) Address City Hospital, #1 **626-60**

17. (a) (b) Date thereof 6-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo.

18. (a) Signature of funeral director J. B. Fisher

(b) Address 3500 City

19. (a) JUL 1 1940 (b) J. B. Fisher
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis **16**
(If outside city or town limits, write "RURAL")
(d) Street No. 3026 Utah St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21,
year 1940 hour 3:40 minute P. M.

21. I hereby certify that I attended the deceased from February
29, 1940, to June 21, 1940
that I last saw him alive on June 21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Thrombosis **4 mos**
with Left Hemiplegia
Due to Hypertension **year**
Due to Arteriosclerosis **year**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None
Of autopsy None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury.....

23. Signature Walter Ford (M. D. or other)
Address 1515 Lafayette Date 6/21/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.