

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34116**

FILED NOV 9 1943
Registration District No. **7**

Primary Registration District No. **1000**

Registrar's No. **1131**

1. PLACE OF DEATH:

(a) County **Euchanan**

(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Sisters Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **5 Weeks**
(Specify whether years, months or days)

In this community.....
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**

(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")

(d) Street No. **26 East Linwood**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Mary Elizabeth Byrne**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **no**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Joseph William Byrne**

6. (c) Age of husband or wife if alive **50** years

7. Birth date of deceased **May 18 1878**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
65	2	23hr.....min.

9. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business.....

12. Name **John Hughes**

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

14. Maiden name **Mary E. Fetzwater**

15. Birthplace **Holt County Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Joseph William Byrne**

(b) Address **26 E. Linwood, Kansas City, Mo**

17. (a) **Burial** (b) Date thereof **Oct. 16 43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olivet Cemetery**

18. (a) Signature of funeral director **Herwan W. Sidupadu**

(b) Address **1802 Union St. Joseph, Mo**

19. (a) **10/16/43** (b) **Obse Stegoy**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **13**
year **1943** hour **8:40** minute **A** M.

21. I hereby certify that I attended the deceased from **July 5 1943** to **Oct 12 1943**;
that I last saw her alive on **Oct 12 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Mel. Carcinoma of lungs (Sec 2)**

Due to **Carcinoma of spine (Pr.)**

Due to.....

Duration

5 months

14 months

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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?

23. Signature **Frank Anderson** (M. D. or other)
Address **620 N. 1st St. Joseph, Mo** Date signed **10/13/43**

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

MOTHER FATHER

1233

(Licensed Embalmer's Statement on Reverse Side)

St Joseph, Mo

Shuttyar

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 *John H Hurley*
Licensed Embalmer No. *4050*
P. O. Address *St Joseph Mo.*

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, fact should be so stated above.