

4-0000  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Francois

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

(c) Name of hospital or institution: Mo. State Hospital No. 4  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 days (Specify whether years, months or days)

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 94

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 346 Rosedale  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME THOMAS HENRY BYRNE

3. (b) If veteran, name war Not a veteran

3. (c) Social Security No. 494-09-8175

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 12  
year 1944 hour 1 minute 10 P.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Helen Saukey

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 9 1885  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from November 27, 1944, to December 12, 1944; that I last saw h. in alive on December 12, 1944; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>6</u>	<u>3</u>	hr. _____ min.

Immediate cause of death Chronic myo-carditis & myocardial degeneration

Due to \_\_\_\_\_

Due to 309

Other conditions CNS has Paros  
(Include pregnancy within 3 months of death)

9. Birthplace Yarmouth, Nova Scotia Canada  
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman, real estate

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Michael Joseph Byrne

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

14. Maiden name Mary Ann

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

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? \_\_\_\_\_

16. (a) Informant Records of State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 12-15-44  
(Month) (Day) (Year)

23. Signature [Signature] (M. D. or other) med  
Address State Hosp No 4 Date signed 12-13-44

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

(c) Place: burial or cremation Calvary Cem.; St. Paul, Minn.

18. (a) Signature of funeral director Arthur J. Donnelly, 3840 Lindell, St. Louis Mo.

(b) Address and O'Halloran & Murphy, 215 W 6 at Main St. Paul, Minn.

19. (a) 1-3-45 (Date received local registrar)

(b) [Signature] (Registrar's signature)

DEPT. OF HEALTH  
ST. LOUIS

District Health Officer No. 7  
District File Number 145-118  
Date Filed 1-16-48

**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 W. H. Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette  
St. Louis

**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.**