

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33982**
9088
Registrar's No. _____

Registration District No. **318**

Primary Registration District No. **1003**

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

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: **St. Louis City Hospital—Max C. Starkloff**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 days** (Specify whether)
15 years (In this community, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")

(d) Street No. **4500 Natural Bridge Avenue** **9**
Memorial (If rural, give location)

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

3. (a) PRINT FULL NAME **NORA BYRD**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **F** / 5. Color or race **W**

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

6. (b) Name of husband or wife **Richard** 6. (c) Age of husband or wife if alive **58** years

7. Birth date of deceased **May 22, 1885**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	63	4	25	hr. _____ min. _____

9. Birthplace: _____ **Missouri** **6**
(City, town, or county) (State or foreign country)

10. Usual occupation **Cook**

11. Industry or business **Resturant**

12. Name **unknown** **9**

13. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **unknown** **9**

15. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Roy W. Hicks**

(b) Address **1830a Park Avenue**

17. (a) **burial** (b) Date thereof **10-20-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mount Hope Cemetery**

18. (a) Signature of funeral director **A.W. McLaughlin**

(b) Address **2501 Lafayette Avenue**

19. (a) **OCT 20 1948** **J. B. Foster**
(Date received local registrar's report) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **17th**
year **1948** hour **6** minute **35 P.** M.

21. I hereby certify that I attended the deceased from **10/14/48**
19____ to **Oct. 17th** 19 **48**

that I last saw her alive on **Oct. 17th** 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic pyelo-** **7 days**
nephritis **?**

Due to **Chronic pyelo-** **?**
nephritis

Due to **183**

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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? **0**

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **William W. Carter** **10/18/48**
Address **1515 Lafayette** Date signed **Wd**

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..... *R. H. Cooper*

Licensed Embalmer No. *3830*

P. O. Address..... *2301 Lafayette*

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.