

FILED MAR 8 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7417

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 367 PRIMARY REG. DIST. NO. 6246 Registrar's No. 4

1100

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

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>WASHINGTON</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>CONCORD RURAL</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>CONCORD RURAL</b>  |  |
| c. LENGTH OF STAY (in this place) <b>1 1/2 mo.</b>  |  | d. STREET ADDRESS (If rural, give location) <b>IRONDALE RR #1</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>IRONDALE RR #1</b>                                     |  |  |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <b>William</b> b. (Middle) <b>AMOS</b> c. (Last) <b>BYNUM</b> |  |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>FEB 26 1950</b> |  |  |
|---|--|--|--|--|--|

|                    |  |                               |  |   |  |                                       |  |   |  |  |  |   |  |   |  |
|--------------------|--|-------------------------------|--|---|--|---------------------------------------|--|---|--|--|--|---|--|---|--|
| 5. SEX <b>MALE</b> |  | 6. COLOR OR RACE <b>WHITE</b> |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b> |  | 8. DATE OF BIRTH <b>MARCH 21 1887</b> |  | 9. AGE (In years last birthday) <b>63</b> if under 1 year <b>11</b> if under 1 month <b>4</b> |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MUSICIAN</b> |  | 11. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b> |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |  |
|--------------------|--|-------------------------------|--|---|--|---------------------------------------|--|---|--|--|--|---|--|---|--|

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| 13a. FATHER'S NAME <b>HENRY Y. BYNUM</b> |  |  |  | 13b. MOTHER'S MAIDEN NAME <b>ELIZABETH HAMPTON</b> |  |  |  | 14. NAME OF HUSBAND OR WIFE <b>CARRIE BYNUM</b> |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|

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|--|--|-------------------------------|--|--|--|--|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO. _____ |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>CARRIE BYNUM IRONDALE RR #1, MO</b> |  |  |  |  |  |
|--|--|-------------------------------|--|--|--|--|--|--|--|

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|---|--|-----------------------|--|--|--|--|--|--|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c) |  | MEDICAL CERTIFICATION |  |  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|-----------------------|--|--|--|--|--|--|--|--|--|----------------------------------|--|

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| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b>  |  | ANTECEDENT CAUSES   |  |  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH               |  |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |  | MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. DUE TO (b) <b>Cardiac decompensation</b> |  |  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH               |  |
|  |  | DUE TO (c) <b>Hypertension</b>  |  |  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH               |  |
| II. OTHER SIGNIFICANT CONDITIONS   |  | Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>4-20/1</b> |  |

|                        |  |                                  |  |  |  |  |  |  |  |  |  |
|------------------------|--|----------------------------------|--|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
|------------------------|--|----------------------------------|--|--|--|--|--|--|--|--|--|

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|--|--|--|--|--|--|---|--|--|--|--|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  |  |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|

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|---|--|--|--|--|--|--|--|----------------------------|--|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) |  |  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |  |  | 21f. HOW DID INJURY OCCUR? |  |  |  |
|---|--|--|--|--|--|--|--|----------------------------|--|--|--|

22. I hereby certify that I attended the deceased from **11-8**, 19**49**, to **2-26**, 19**50**, that I last saw the deceased alive on **2-6**, 19**50**, and that death occurred at **10:30 p.m.**, from the causes and on the date stated above.

|  |  |  |  |                                 |  |  |  |                                 |  |  |  |
|--|--|--|--|---------------------------------|--|--|--|---------------------------------|--|--|--|
| 23a. SIGNATURE (Degree or title) <b>Edward W. Love, Jr. M.D.</b> |  |  |  | 23b. ADDRESS <b>Cotoni, Mo.</b> |  |  |  | 23c. DATE SIGNED <b>2/27/50</b> |  |  |  |
|--|--|--|--|---------------------------------|--|--|--|---------------------------------|--|--|--|

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|---|--|------------------------------|--|--|--|--|--|---|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> |  | 24b. DATE <b>FEB 28 1950</b> |  | 24c. NAME OF CEMETERY OR CREMATORY <b>ADAMS CEMETERY</b> |  |  |  | 24d. LOCATION (City, town, or county) (State) <b>FRANKCLAY MO</b> |  |  |  |
|---|--|------------------------------|--|--|--|--|--|---|--|--|--|

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|--|--|--|--|--|--|-----|--|--|--|--|--|--|--|
| DATE REC'D BY LOCAL REG. <b>FEB. 28-1950</b> |  | REGISTRAR'S SIGNATURE <b>Jessie Eichenberger</b> |  |  |  | 338 |  |  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bert L. Boyer, Leadwood, Mo.</b> |  |  |  |
|--|--|--|--|--|--|-----|--|--|--|--|--|--|--|

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RECEIVED

MAR 7 1950

DISTRICT HEALTH OFFICE No. 4

File No. 350-321

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Switzer

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Bert L. Boyer

Licensed Embalmer No. 3440

P. O. Address Leadwood 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.

*Mr. [unclear] Leadwood Mo. Bert L. Boyer, Licensed Embalmer No. 3440*