

FILED APR 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11024

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 367

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| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Joseph | | c. CITY OR TOWN St. Joseph | |
| c. LENGTH OF STAY (In this place) life | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Meth. Hospital | | e. STREET ADDRESS (If rural, give location) 817 Garden St. 01170 | |

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|-------------------------------------|--------------------|------------------|-----------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) WILLIAM | b. (Middle) EARL | c. (Last) BYOUS | 4. DATE OF DEATH (Month) (Day) (Year) March 31, 1955 |
|-------------------------------------|--------------------|------------------|-----------------|---|

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|---|------------------------|--|--------------------------------|------------------------------------|-----------------------------|-----------------------------|
| 5. SEX Male <input checked="" type="checkbox"/> | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Aug. 11, 1911 | 9. AGE (In years last birthday) 43 | If UNDER 1 YEAR Months Days | If UNDER 24 HRS. Hours Min. |
|---|------------------------|--|--------------------------------|------------------------------------|-----------------------------|-----------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, Tank House | 10b. KIND OF BUSINESS OR INDUSTRY Meat Packing Industry Swift & Co. | 11. BIRTHPLACE (City and State or Foreign Country) <input checked="" type="checkbox"/> St. Joseph Mo. | 12. CITIZEN OF WHAT COUNTRY? U.S.A |
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| 13a. FATHER'S NAME William Byous | 13b. MOTHER'S MAIDEN NAME Maude Hughes | 14. NAME OF HUSBAND OR WIFE Helen Byous |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. 487-05-1441 | 17. INFORMANT'S SIGNATURE OR NAME Helen Byous | ADDRESS 817 Garden St., City |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Carcinomatosis - liver</i> | | <i>3 mo</i> |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Carcinoma - pancreas</i> | | <i>8 mo</i> |
| DUE TO (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Emasciation - Januaria</i> | | <i>157 X</i> | |

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| 19a. DATE OF OPERATION 7-6-54 | 19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma pancreas; common bile duct obstruction</i> | 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 _____, 1935, to 3-31, 1955, that I last saw the deceased alive on 3-31, 1955, and that death occurred at 1035 pm., from the causes and on the date stated above.

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| 23a. SIGNATURE <i>E. J. Grant M.D.</i> | (Degree or title) <i>M.D.</i> | 23b. ADDRESS <i>St. Joseph Mo</i> | 23c. DATE SIGNED <i>4-1-55</i> |
|---|-------------------------------|--------------------------------------|-----------------------------------|

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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24b. DATE <i>April 2, 1955</i> | 24c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cem.</i> | 24d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo.</i> |
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| DATE REC'D BY LOCAL REG. <i>April 11, 1955</i> | REGISTRAR'S SIGNATURE <i>Esther M. Allison</i> | 25. FUNERAL DIRECTOR'S SIGNATURE <i>Emmanuel</i> | ADDRESS <i>Clark Funeral Home St. Joseph, Mo.</i> |
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

JUN 1 1955

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.....
Signature of Student Embalmer

Signed *Earl A. Clark*.....

Licensed Embalmer No. *41*.....

P. O. Address *St. Joseph*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.