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FILED JAN 6 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41891**
Registrar's No. **11260**

318 PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11260	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO.		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		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 2525 North Market Str.				e. STREET ADDRESS (If rural, give location) 20 2525 North Market Str. 32090			
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM		b. (Middle) E		c. (Last) BYRD.		4. DATE OF DEATH (Month) (Day) (Year) Dec. 22 1955.	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married.		8. DATE OF BIRTH May 12, 1901	
9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months _____		IF UNDER 24 HRS. Days _____		IF UNDER 24 HRS. Hours _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing		11. BIRTHPLACE (City and State or Foreign Country) Ironton Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Byrd		13b. MOTHER'S MAIDEN NAME Sarah Sutterfield		14. NAME OF HUSBAND OR WIFE Doris Byrd (nee Boehm)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 494-09-9112		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Doris Byrd 2525 North Market Str.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left Ventricular failure ANTECEDENT CAUSES DUE TO (b) Yersal infection chest. DUE TO (c) virus infection kidneys. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 days. 7 wks. 8 days.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 492x				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		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 12-12- , 19 55 , to 12-22 , 19 55 , that I last saw the deceased alive on 12-22- , 19 55 , and that death occurred at 4:30 A. m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Russell Shaw				23b. ADDRESS 802 4032 N. Flannigan Ave		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Dec. 24, 1955		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
DATE REC'D BY LOCAL REG. DEC 23 1955		REGISTRAR'S SIGNATURE J. Carl Smith Mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hy. Leidner Und. Co 2223 St. Louis Ave.			

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

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..... *G. W. Wilkins*

Licensed Embalmer No. *35*

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