

Health, & Welfare
Public
Services

S. 308
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 27 1957

STANDARD CERTIFICATE OF DEATH

39545

STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 169

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u> c. CITY OR TOWN <u>Harrisonville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Harrisonville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Rural Grand River Twp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u> Length of stay in 1b <u>6 days</u>		d. STREET ADDRESS (If outside, give location) <u>7 mi S.W. of Harrisonville</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MYRTLE</u> Middle <u>BYBEE</u> Last <u>BYBEE</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1957</u>		
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5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28 1886</u>	9. AGE (In years last birthday) <u>71</u>	10. FUNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Cass Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>James Thornton Parker</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Taylor Zion</u>	14. NAME OF HUSBAND OR WIFE <u>Walter E. Bybee</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>494-40-3557B</u>	17. INFORMANT <u>Walter E. Bybee</u> Address <u>Harrisonville Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		<u>UNKNOWN</u>
DUE TO (c) <u>4200</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>BILATERAL RENAL CALCULI & CHR. NEPHRITIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED.. (Enter nature of injury in PART I or PART II of item 18.)
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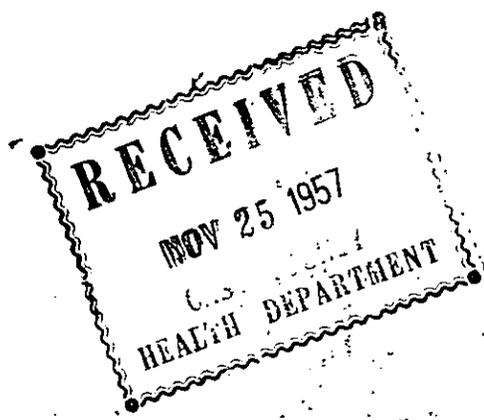
20c. TIME OF INJURY Hour <u>9:30</u> Month <u>Nov.</u> Day <u>16</u> Year <u>1957</u> a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Harrisonville</u> COUNTY <u>Cass</u> STATE <u>Mo.</u>
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21: I attended the deceased from Death occurred at <u>9:30 PM</u> on <u>Nov. 16, 1957</u> to <u>Nov. 16, 1957</u> and last saw <u>her</u> alive on <u>Nov. 16, 1957</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>[Signature] MD</u>	22b. ADDRESS <u>Harrisonville Mo</u>	22c. DATE SIGNED <u>18 Nov. 1957</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rural</u>	23b. DATE <u>Nov 19 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Freeman Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Harrisonville Mo.</u>
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24. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>Harrisonville Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 19, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Dora Barward</u>
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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 *James R. Phillips*
Licensed Embalmer No. *4681*
P. O. Address *Harrisonville*

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.