

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002609  
STATE FILE NUMBER

FILED FEB 3 1959

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 31

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Irondale</u> 1940 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp.</u>		Length of stay in lb <u>2 days</u>	d. STREET ADDRESS (If outside, give location) <u>Rfd. #1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Goodman Byers</u>			4. DATE OF DEATH Month Day Year <u>Jan. 22, 1959</u>
5. SEX <u>male</u>	6. COLOR OR 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>Aug. 24, 1881</u>
9. AGE (In years last birthday) <u>77</u>		10. FUNDER 1 YEAR Months Days <u>+</u> <u>+</u>	IF UNDER 24 HRS. Hours Min. <u>+</u> <u>+</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>pump operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lead Mine</u>	11. BIRTHPLACE (City and state or country) <u>Marquand, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Goodman Hugh Byers</u>	
13b. MOTHER'S MAIDEN NAME <u>Martha Jackson</u>		14. NAME OF HUSBAND OR WIFE <u>Etta Byers</u>	
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>None</u>	17. INFORMANT Address <u>Etta Byers, Irondale R#1, Mo.</u>
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>Cerebral hemorrhage</u> DUE TO (b) <u>Hypertensive vascular disease</u> DUE TO (c) <u>unknown</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> OR AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>Jan 18, 1959</u> to <u>Jan 22, 1959</u> Death occurred at <u>Irondale</u> on the date stated above; and to the best of my knowledge from the causes stated.		I could last saw him alive on <u>Jan 22, 1959</u>	
22a. SIGNATURE <u>J. L. Foster</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>Dealage Mo</u>	22c. DATE SIGNED <u>23 Jan 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Jan. 25, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Adams Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Frankclay, Missouri</u>
24. FUNERAL DIRECTOR <u>Bert L. Boyer</u> ADDRESS <u>Leadwood, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan. 29, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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

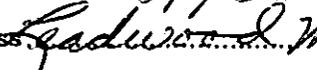
STATEMENT BY LICENSED EMBALMER

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  .....

Licensed Embalmer No. 3445 .....

P. O. Address  .....

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.