

Health, Welfare & Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014525
STATE FILE NUMBER

FILED APR 27 1958 Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 109

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1-57 0

1. PLACE OF DEATH a. COUNTY St. Charles			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Charles		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Ann		4001 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hosp.		Length of stay in lb 4 Days	d. STREET ADDRESS (If outside, give location) 11117 Ivan		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Martha Middle E. Last Byrd			4. DATE OF DEATH Month April Day 23 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 26, 1889	9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and state or country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Sam Jackson		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Virgil J. Byrd	
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. None	17. INFORMANT Virgil Byrd 11117 Ivan Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia lobor					INTERVAL BETWEEN ONSET AND DEATH 72 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Pleural Effusion Right					48 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Tracheotomy old - Tracheal softening					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 April 20 1959 to April 23 1959 and last saw her/him alive on April 23 1959 Death occurred at 3:15 pm on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Sam B. Tauran (Degree or title) MD			22b. ADDRESS St. Louis County Mo		22c. DATE SIGNED April 24 1959
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/27/1959	23c. NAME OF CEMETERY OR CREMATORY Fee Fee Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR Collier Mortuary, St. Ann, Mo.		ADDRESS	25. DATE RECD. BY LOCAL REG. Apr 24-1959		26. REGISTRAR'S SIGNATURE Marcella Wilson

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 30 1959

MAY 6 1959

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 *Sheldon Collier*

Licensed Embalmer No. *3382*

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