

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026473

FILED VS AUG 13 1959

2 7245

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO.		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOBP. #1.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1604 S. 14th
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last MARIE BYRD	4. DATE OF DEATH Month Day Year AUG. 3, 1959
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-20-1895	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Mansfield, Ill.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John Fry	13b. MOTHER'S MAIDEN NAME Maude Barnhart	14. NAME OF HUSBAND OR WIFE Robert (Deceased)
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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. Unknown	17. INFORMANT Address Dorothy Schlangen, 2918a Sidney
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Septicemia</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>acute suppurative pyelonephritis</i>	
	DUE TO (c) <i>cerebrovascular accident</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from 7/20/59 to 8/3/59 and last saw her <sup>him</sup> alive on 8/3/59  
Death occurred at 11:30 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Robert K. Lay M.D.</i>	22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 8/3/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-5-1959	23c. NAME OF CEMETERY OR CREMATORY National	23d. LOCATION (City, town, or county) (State) Jeff. Barracks, Mo.
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24. FUNERAL DIRECTOR ADDRESS McLaughlin Funeral Home, Inc. 301 Lafayette, St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. AUG 5 '59	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*A. G. Farris*

Licensed Embalmer No.

*3384*

P. O. Address

*A. G. Farris*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.