

# MORTUARY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. DEC 29 1959 *209*

'59 0 4 4 7 5 5

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. *3043* Registrar's No. *388*

UNRECORDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARION</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u> Length of stay in Ib <u>2 Days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St ELIZABETH HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MARION</u> c. CITY OR TOWN <u>MONROE CITY</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>ROUTE 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>JOHN</u> Middle <u>ALEXANDER</u> Last <u>BYRD</u>			<b>4. DATE OF DEATH</b> Month <u>DECEMBER</u> Day <u>10</u> Year <u>1959</u>				
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8-30-1884</u>	<b>9. AGE (last birthday)</b> <u>75</u>	IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR: _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN FARM</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>MARION COUNTY, MO</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>		
<b>13a. FATHER'S NAME</b> <u>JOHN BYRD</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>MARY ETTA KINCAID</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>HAZEL BYRD</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>492-42-7186</u>	<b>17. INFORMANT</b> Address <u>Mrs Hazel Byrd Monroe City Mo. R 3.</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ 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 type="checkbox"/> No <input type="checkbox"/> Unknown					INTERVAL BETWEEN ONSET AND DEATH <u>2 da.</u>		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	Month, Day, Year _____						
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>		
<b>21. I attended the deceased from</b> <u>12/9/59</u> to <u>12/10/59</u> and last saw her/him alive on <u>12/10/59</u> Death occurred at <u>10.30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <u>[Signature]</u> (Degree or title)			<b>22b. ADDRESS</b> <u>Palmyra Mo.</u>		<b>22c. DATE SIGNED</b> <u>12/12/59</u> (State)		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>	<b>23b. DATE</b> <u>12-13-59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ANDREW CHAPEL</u>		<b>23d. LOCATION</b> (City, town, or county) <u>MARION COUNTY, MO</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Wilson Home Monroe City Mo</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>12/15/59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Eam. Lube</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 25 1962

**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 me \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Leola L. Nelson

Licensed Embalmer No. 3014

P. O. Address Monroe City

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