

**UNITED STATES DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS DEC 21 1959**

'59 0 45 2 9 3

**211282**

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)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		a. STATE <b>Mo.</b> b. COUNTY <b>Deming</b>	
Length of stay in 1b		c. CITY OR TOWN <b>Steele, Missouri</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>Cardinal Glennon Memorial</b> INSTITUTION <b>Hospital for Children</b>		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Marie</b> Last <b>Byrd</b>			4. DATE OF DEATH Month <b>12</b> Day <b>4</b> Year <b>59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-24-59</b>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b>	IF UNDER 24 HR Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Kennett, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>

13a. FATHER'S NAME <b>J. W. Byrd</b>	13b. MOTHER'S MAIDEN NAME <b>Hampton</b>	14. NAME OF HUSBAND OR WIFE
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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) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>J. H. Byrd</b> Address <b>Steeles, Mo.</b>
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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) <b>Bronchopneumonia - from aspiration</b>		<b>2 d.</b>
DUE TO (b) <b>Tracheo-esophageal fistula</b>		<b>Congenital</b>
DUE TO (c) <b>&amp; esophageal atresia. 756.2</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Imperforate anus &amp; congenital sinus anomaly</b>		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 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, item 18.)
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20c. TIME OF INJURY Hour <b>4:55</b> a.m. <b>PM</b> Month, Day, Year <b>11-26-59</b>	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 **11-26-59** to **12-4-59** and last saw her alive on **12-4-59**  
 Death occurred at **4:55 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Charles G. High M.D.</b>	22b. ADDRESS <b>1465 So. Laurel, Mo.</b>	22c. DATE SIGNED <b>12-5-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify). <b>Removed</b>	23b. DATE <b>12-5-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Steeles, Mo</b>	23d. LOCATION (City, town, or county) (State) <b>Steeles, Mo</b>
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24. FUNERAL DIRECTOR <b>Hoppe Funeral - 4911 Washington St. - St. Louis, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 5 1959</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed \_\_\_\_\_  
*No embalmer*  
*Charles J. Fe...*

Licensed Embalmer No. \_\_\_\_\_

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.