

**FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH**

FILED VS NOV 10 1960

**-60-039596**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10701** STATE FILE NUMBER

|                                                                                                                                               |  |                                                                                                                        |                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis Mo.</b>                                                                                           |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |                                                                                 |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>St. Louis</b>                                                                 |  | Length of stay in 1b<br><b>9-yrs.</b>                                                                                  | c. CITY OR TOWN <b>St. Louis</b>                                                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>3225 N. Florissant Ave.<br/>Little Sister's of the Poor</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                   | d. STREET ADDRESS (If outside, give location)<br><b>3225 No. Florissant Ave</b> |
|                                                                                                                                               |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                  |                                                                                 |

|                                                                                                                       |                            |                                                                                                                                                             |                                                                                   |                                                              |                                                                |
|-----------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Margaret</b> Middle <b>Mary</b> Last <b>Byrd</b>                      |                            |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>4th</b> Year <b>1960</b>             |                                                              |                                                                |
| 5. SEX <b>F</b>                                                                                                       | 6. COLOR OR RACE <b>W.</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>12/22/1891</b>                                                | 9. AGE (last birthday) <b>68</b>                             | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HR<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>       |                            | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                                                           | 11. BIRTHPLACE (City and state or country)<br><b>Dexter Mo.</b>                   |                                                              | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                   |
| 13a. FATHER'S NAME<br><b>Marius Mosteller</b>                                                                         |                            | 13b. MOTHER'S MAIDEN NAME<br><b>Mary Hortoem</b>                                                                                                            |                                                                                   | 14. NAME OF HUSBAND OR WIFE<br><b>Wm Lee Byrd (Deceased)</b> |                                                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b> |                            | 16. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                      | 17. HOME ADDRESS<br><b>3225 N. Florissant Ave.<br/>Little Sisters of the Poor</b> |                                                              |                                                                |

|                                                                                                          |                            |                                        |                                                                |
|----------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------|----------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |                            |                                        | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>???</b> |
| IMMEDIATE CAUSE (a)                                                                                      | <b>Coronary infarction</b> |                                        |                                                                |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.               | DUE TO (b)                 | <b>Arterio-sclerotic heart disease</b> |                                                                |
|                                                                                                          | DUE TO (c)                 | <b>420.0</b>                           |                                                                |

|                                                                                                                                                  |  |  |                                                                                                                                                                                 |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>None</b> |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|

|                                                                                                   |                                        |                                  |                                   |                                                                                              |  |
|---------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------|-----------------------------------|----------------------------------------------------------------------------------------------|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 **May 12 1960** to **Nov. 4. 1960** and last saw her <sup>him</sup> alive on **Nov 3, 1960**  
Death occurred at **7 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

|                                             |                |                                           |                                    |
|---------------------------------------------|----------------|-------------------------------------------|------------------------------------|
| 22a. SIGNATURE<br><b>Donald H. Rotte MD</b> | (Dr. or Title) | 22b. ADDRESS<br><b>2435 N. Grand Blvd</b> | 22c. DATE SIGNED<br><b>11-4-60</b> |
|---------------------------------------------|----------------|-------------------------------------------|------------------------------------|

|                                                            |                               |                                                               |                                                                       |
|------------------------------------------------------------|-------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>11/7/1960</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis Mo.</b> |
|------------------------------------------------------------|-------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------------|

|                                               |                                    |                                                   |                                                |
|-----------------------------------------------|------------------------------------|---------------------------------------------------|------------------------------------------------|
| FEDERAL DIRECTOR<br><b>Arthur J. Donnelly</b> | ADDRESS<br><b>3840 Lindell Bl.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>NOV 5 1960</b> | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith</b> |
|-----------------------------------------------|------------------------------------|---------------------------------------------------|------------------------------------------------|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. F. E. ...  
2435 N. ...

3:30 P.M.

6:54:77

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed W. M. ...

Licensed Embalmer No. 469

P. O. Address 5840 ...

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.