

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ED VS JAN 3 1961

-60-048414

STATE FILE NUMBER

Registration District No. 322 Primary Registration District No. 307/ Registrar's No. 55

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Slater</u>		Length of stay in lb <u>3 Yrs.</u>		c. CITY OR TOWN <u>Slater</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Walnut St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Walnut St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>R</u> Last <u>BYARS</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>28</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2/19/1898</u>		9. AGE (last birthday) <u>67</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Switchman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>GM &amp; O Railroad</u>		11. BIRTHPLACE (City and state or country) <u>Grand Pass, Mo.</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>John H. Byars</u>				13b. MOTHER'S MAIDEN NAME <u>Fannie Proctor</u>				14. NAME OF HUSBAND OR WIFE <u>Rovilla Byars</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>4109 Main St</u> <u>Mrs. John O'Brien, Kansas City, Mo</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Secondary Anemia from</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Gastric Bleeding</u> DUE TO (c) <u>Carcinoma of Stomach</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u> <u>6 mo.</u>			
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			
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.)									
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year											
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					
21. I attended the deceased from <u>Oct. 3, 1960</u> to <u>Dec. 28, 1960</u> last saw him alive on <u>Dec. 15, 1960</u> Death occurred at <u>6:30 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>C. A. McE...</u> (Degree or title)				22b. ADDRESS <u>Slater, Mo</u>				22c. DATE SIGNED <u>12/28/60</u> (State)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12/30/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Town</u>				23d. LOCATION (City, town, or county) <u>Kansas City, Mo.</u>					
24. FUNERAL DIRECTOR <u>Haines Funeral Home Slater, Mo</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>12.30-60</u>		26. REGISTRAR'S SIGNATURE <u>Dr. Raymond Brame</u>							

DOCUMENT

MEDICAL CERTIFICATION

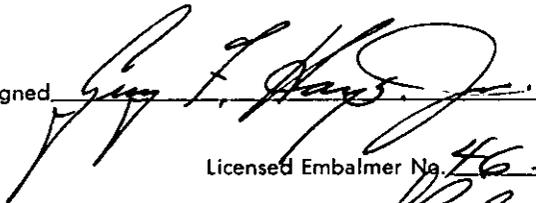
BY AFFIDAVIT OF

VS JAN 4 1961

**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  \_\_\_\_\_

Licensed Embalmer No. 4630

P. O. Address Water, 7

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.