

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-029609**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 316 Primary Registration District No. 5075 Registrar's No. 317

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED AUG 1 1963**

VS 300  
Rev. 4/59

1 0940

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |   |   |   |   |   |  |
|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Francois</b>  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Scott</b> |   |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP, only)<br>OR TOWN <b>St. Francois Twp. Farmington/ Rural</b>  |   | Length of stay in 1b<br><b>11Yrs. 2das</b>  | c. CITY OR TOWN <b>Sikeston</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>State Hospital #4</b>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>801 Delmar (rear)</b>   |   | Reside on farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Lula</b> Middle <b>Bell</b> Last <b>Byrd</b>   |   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>23</b> Year <b>1963</b>  |   |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</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<br><b>2/21/84</b>  | 9. AGE (last birthday)<br><b>79</b>   | IF UNDER 1 YEAR<br>Months Days 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<br><b>Home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Decatur County, Tenn.</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |  |
| 13a. FATHER'S NAME<br><b>Moril Tinsley Pratt</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Isabelle c Doyle</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>James Edgar Byrd, dec.</b>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.   | 17. INFORMANT <b>Records, State Hsppt. #4, and Eddie Byrd, Sikeston, Mo.</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction - - - - -</b>  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 das.</b>                                     |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Arteriosclerotic Heart Disease - - - - -</b>  |   |   |   |   | <b>Unknown.</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)<br><b>Dementia Praecox Psychosis - - Abt. 31 years.</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 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<br>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 <b>July 21, 1963</b> to <b>July 23, 1963</b> and last saw her alive on <b>July 23, 1963</b><br>Death occurred at <b>5:40 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |   |   |  |
| 22a. SIGNATURE<br><i>John A. Brennan M.D.</i> (Degree or title)   |   | 22b. ADDRESS<br><b>State Hospital No. 4 Farmington, Mo.</b>   |   | 22c. DATE SIGNED<br><b>7-23-63</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>7/25/63</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park Cemetery</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Sikeston, Missouri</b>  |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>McMikle, Charleston, Missouri</b> ADDRESS  |   | 25. DATE RECD. BY LOCAL REG.<br><b>July 23, 1963</b>  | 26. REGISTRAR'S SIGNATURE<br><i>Ether Rudloff</i>   |   |   |  |

USE BLACK INK OR TYPEWRITER RIBBON

AUG 2 1963

**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

*Bruce R. Austin*

Licensed Embalmer No. 5149

P. O. Address Charleston, Mo.

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.