WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.
33552

1. PLACE OF DEATH

County.................. Registration District No. 781
Township.................. Primary Registration District No. 1003
City St Louis (No. City Hosp St. Ward)

File No. ....
Registered No. 10353

2. FULL NAME James Byrd

(a) Residence. No. 1418 Chouteau St., 22 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. If Married, Widowed, or Divorced HUSBAND of (or) WIFE of: Minnie Byrd

6. DATE OF BIRTH (month, day and year): Mch 24 - 1894

7. AGE: Years 32, Months 7, Days 4. If LESS than 1 day, ...hrs. or ......min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): soft Drink Parlor
(c) Name of employer

9. BIRTHPLACE (city or town): De Soto MO
(State or country)

PARENTS
10. NAME OF FATHER: Luther Byrd
11. BIRTHPLACE OF FATHER (city or town): Desoto
(State or country) MO
12. MAIDEN NAME OF MOTHER: Effie Port
13. BIRTHPLACE OF MOTHER (city or town): MO
(State or country)

14. INFORMANT: Minnie Byrd
(Address) 1418 Chouteau ave

15. FILED NOV -3 1926 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day and year) Oct 30 1926

17. I HEREBY CERTIFY, That I attended deceased from ...., 19....., to ...., 19.....
that I last saw h..... alive on ...., 19....., and that death occurred, on the date stated above, at 11-40 P. m.

THE CAUSE OF DEATH* was as follows:
Hemorrhagic Pancreatitis
178
W.M.C. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 125
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? .... DATE OF ....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. W. Fath M.D.
11/1, 1926 (Address) Deputy Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: New St Marcus
DATE OF BURIAL: Nov 3 1926

20. UNDERTAKER: Frank Hettlage
ADDRESS: 917 Chouteau

United States Standard ertificate of Death

y U. S. Census and American Public Health Association.)

ut of Occupation.—Precise statement of very important, so that the relative f various pursuits can be known. The s to each and every person, irrespec- For many occupations a single word or first line will be sufficient, e. g., *Farmer or ysician, Compositor, Architect, Locomo- er, Civil Engineer, Stationary Fireman,* many cases, especially in industrial em- it is necessary to know (*a*) the kind of lso (*b*) the nature of the business or In- therefore an additional line is provided r statement; it should be used only when s examples: (*a*) *Spinner*, (*b*) *Cotton mill*, n, (*b*) *Grocery*, (*a*) *Foreman*, (*b*) *Auto- ry.* The material worked on may form he second statement. Never return "Foreman," "Manager," "Dealer," etc., ore precise specification, as *Day laborer, er, Laborer—Coal mine*, etc. Women at are engaged in the duties of the house- (not paid *Housekeepers* who receive a alary), may be entered as *Housewife*, or *At home*, and children, not gainfully as *At school* or *At home.* Care should to report specifically the occupations of ngaged in domestic service for wages, as *Cook, Housemaid*, etc. If the occupation changed or given up on account of the CAUSING DEATH, state occupation at be- of illness. If retired from business, that ay be indicated thus: *Farmer* (*retired*, 6 For persons who have no occupation what- rite *None.*

atement of Cause of Death.—Name, first, the SE CAUSING DEATH (the primary affection with ot to time and causation), using always the e accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite)' *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of ———— (name origin; "Cancer" is less definite; avoid use of "Tumor', for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.