

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

Do not use this space.

27208

1. PLACE OF DEATH

County Jefferson
Towship Kear
City Kear City

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. 35000

(No. 1208 West 18th)

St. _____ Ward) _____

2. FULL NAME

Archib Byrd Jr

(a) Residence. No. 1208 W 18 St. _____ Ward. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 23 mos. 13 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)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

June 23-1927

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

2

13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

10. NAME OF FATHER

Archib Byrd

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Okla.

12. MAIDEN NAME OF MOTHER

Eva Hilgore

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

14.

INFORMANT
(Address)

Correlia Hilgore
1208 W 18th St

15.

FILED

9-10-1927

M M Crowe
Asst

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Sept 10 1927

17.

I HEREBY CERTIFY, That I attended deceased from Aug 7 1927, to Sept 10 1927, that I last saw him alive on Sept 9 1927, and that death occurred, on the date stated above, at 3:10 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

whooping cough
9

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. ✓

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) D O Klepinger M. D.
Sept 10, 1927 (Address) 2322 Summit

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Excelsior Sp. MO

9/10 1927

20. UNDERTAKER

ADDRESS

Mrs C. L. Luster

City

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.

PERMANENT RECORD

