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

Do not use this space.

30727

1. PLACE OF DEATH
County Livingston — Registration District No. 413
Township Mineral — Primary Registration District No. 5559
City Wheeling (No. ..... St. ..... Ward) — File No. ..... Registered No. 2015

2. FULL NAME Lafe W. Byrd

(a) Residence. No. ..... 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. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF ~~(OR) WIFE OF~~ Fanny Byrd

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 22 1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	67	X	28	

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

9. BIRTHPLACE (CITY OR TOWN) Livingston Co.
(STATE OR COUNTRY) Indiana

PARENTS

10. NAME OF FATHER Wm C. Byrd
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) S. C.
12. MAIDEN NAME OF MOTHER Emma Mullen
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ind

14. INFORMANT George Byrd
(Address) Webb City Mo.

15. FILED Nov 10 1927 J. C. Barson — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 20 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Oct 20, 1927, that I last saw h[illegible] alive on Oct 19, 1927, and that death occurred, on the date stated above, at 11:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Brights Disease
131
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) 1290
(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? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) B. M. Henry, M. D
10/22, 1927 (Address) Alba Mo.

*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 Pleasant Hill Cem — DATE OF BURIAL 10/22 1927

20. UNDERTAKER Webb City Und Co — ADDRESS Webb City Mo.

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.

NOV