

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

Do not use this space

37379

JAN 19 1929

1. PLACE OF DEATH  
 County Laclede Registration District No. 449  
 Township Lebanon Primary Registration District No. 5609  
 City (No. ) St. (Ward)

File No. \_\_\_\_\_  
 Registered No. 1420

2. FULL NAME Jacir F. Byrne  
 (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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 4 1859  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
68 | 1 | 27 | \_\_\_\_\_  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Housewife  
 (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) Anderson, Calm  
 10. NAME OF FATHER Jacir W. Williams  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Dont know  
 12. MAIDEN NAME OF MOTHER Dont know  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Dont know

14. INFORMANT J. P. Meyer  
 (Address) Lebanon, Mo. R# 3

15. FILED 11, 1929 J. M. Bellamy  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-31-1927  
 17. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1927, to Dec 30, 1927, that I last saw h. or alive on Dec 26, 1927, and that death occurred, on the date stated above, at 10-30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral Hemorrhage

99A  
 (duration) yrs. mos. ds. 74  
 CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
 (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) J. P. Herbert, M. D.  
1231, 1927 (Address) Lebanon, 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 Mexico MO DATE OF BURIAL 1

20. UNDERTAKER Helmont Stewart ADDRESS Lebanon Mo

11/22/02

11/22/02

11/22/02

11/22/02

11/22/02

11/22/02

11/22/02

11/22/02

11/22/02

11/22/02

11/22/02

11/22/02

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Clade  
Township Lebanon  
City..... (No..... St..... Ward)

Registration District No. 449  
Primary Registration District No. 5666

File No.....  
Registered No. 1420

2. FULL NAME

Jacie F. Seger

(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)

M W M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... (duration) yrs. mos. ds.  
(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 2/16/25 J. M. Bellinger REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-31-27

17. I HEREBY CERTIFY, That I attended deceased from..... to..... that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

..... (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)..... (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)....., M. D.

, 19 (Address)

\*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

Mexico MO do not know 19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

SEE INSTRUCTIONS FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PER

SEE BY LAW

S-37379