

JAN 22 1929

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

39825

1. PLACE OF DEATH

County CedarRegistration District No. 163

Township

Primary Registration District No. 4095City Donado Springs (No.)

File No.

Registered No. 65

St.

Ward)

2. FULL NAME

William M. Bybee

(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

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

5A. If MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(or) WIFE OFsarah Bybee

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

Jan 14 - 1840

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1

day, ... hrs.

or min.

881110

8. OCCUPATION OF DECEASED

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

minister

(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)

Missouri

10. NAME OF FATHER

James Bybee

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ky.

12. MAIDEN NAME OF MOTHER

Kemp.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ky.

14.

INFORMANT

(Address)

Mrs. J. D. HendricksDonado Springs

15.

FILED

Dec 25, 1928J. W. Dawson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Dec 2419 28

17.

I HEREBY CERTIFY, That I attended deceased from

Dec 2219 28to Dec 2419 28

that I last saw him alive on

Dec 2319 28

and that death occurred, on the date stated above, at

7:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
He died in a state
of collapse & general
debility & had attended him
before my visit
 CONTRIBUTORY (SECONDARY) 107A

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

18. DID AN OPERATION PRECEDE DEATH

DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

M. D.

12-25-1928 (Address)

Dr. D. W. C. Jones

*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

City Cem.12-25 19 28

20. UNDERTAKER

ADDRESS

J. B. Napier - Donado Springs

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**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Pedar

Registration District No. 163

File No. _____

Township _____

Primary Registration District No. 4095

Registered No. 65

City El Dorado Springs

St. _____ Ward) _____

2. FULL NAME

(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)

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

(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 2-5-1929

J. W. Dawson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/24 1928

17.

I HEREBY CERTIFY That I attended deceased from _____

that I last saw h. _____ alive on _____, 19____, and that
death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Overdose - he was in
a state of collapse & several
doctors had attended him
before my sister
Dr. Broncho

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) _____, 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

19

20. UNDERTAKER

ADDRESS

N. B.—Every part 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.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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