

PLACE OF DEATH

County LacledeTownship Elbridge

Village _____

City _____ (NO. _____)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 451File No. 8Primary Registration District No. 5616

Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Horace W. Byrd

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE W SINGLE married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH July 27, 1984
(Month) (Day) (Year)

AGE 82 yrs. 3 mos. 14 ds.
If LESS than
1 day, ____ hrs.
or ____ min.?

OCCUPATION

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

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

BIRTHPLACE

(City or town, State or foreign country) Ark -

PARENTS

NAME OF FATHER Andrew ByrdBIRTHPLACE OF FATHER Mo -MAIDEN NAME OF MOTHER Mary LaughlinBIRTHPLACE OF MOTHER Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Emma Byrd(ADDRESS) Elbridge MoFiled Nov 12, 1929. Emma Byrd

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Nov 10, 1929
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 21, 1929, to Nov 10, 1929

that I last saw him alive on Nov 10, 1929, and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows:

Chronic & congestive

13 1/2 (Duration) yrs. mos. ds.

Contributory none

(Duration) yrs. mos. ds.

(Signed) E. C. Claiborne M. D.Nov 22, 1929 (Address) Deatonsville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the ____ yrs. ____ mos. ____ ds.

Where was disease contracted If not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

Roman Catholic

UNDERTAKER

E. R. Swartz

DATE OF BURIAL

Nov 11, 1929

ADDRESS

Elbridge

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

PLACE OF DEATH

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

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County _____ Township _____ of _____ Registration District No. _____ File No. _____
 Village _____ or _____ Primary Registration District No. _____ Registered No. _____
 City _____ (NO. _____) St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____ SINGLE _____ MARRIED _____ WIDOWED _____ OR DIVORCED _____ (If write the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____
 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
 (City or town, State or foreign country) _____

NAME OF FATHER _____

BIRTHPLACE OF FATHER
 (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER
 (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____

(ADDRESS) _____

Filed _____, 191____, REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY) _____

(Signed) _____ (Address) _____ M. D.

*State the Disease, Causative Death, of, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted if not at place of death? _____ Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

UNDERTAKER _____ ADDRESS _____