LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

JUN 24 1930

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

~~23~~ 4562-1

1. PLACE OF DEATH
County Adair Registration District No. 804 File No.
Township Polk Primary Registration District No. 3803 Registered No.
City Greentop R.R.2. (No. St. Ward)

2. FULL NAME Richard Johnson Byrd

(a) Residence. No. farm home St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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.

## 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~~ Sarah Byrd

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 30 1860

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 70 | 2 | 1 | |

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) Greentop — R.R.2
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Scottie Byrd
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Polly Byrd
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Kentucky

14. INFORMANT Mrs. Jasper Westerns
(Address) Greentop, Mo., R.R.2

15. FILED April 1930 Mrs O. P. Farrington REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 31 1930

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1929, to Mar. 31, 1930, that I last saw h. alive on Mar. 30, 1930 and that death occurred, on the date stated above, at 1 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
auricular Fibrillation
9571
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 9020 (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) Ralph O. Stricklen, M. D.
, 19 (Address) Kirksville 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 | DATE OF BURIAL |
|---|---|
| Hazel Creek Union graveyard-Adair | April 1 1930 |
| 20. UNDERTAKER | ADDRESS |
| L. O. Young | Greentop, Mo. |

LOCAL REGISTRAR'S REPORT—DO NOT

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### CERTIFICATE OF DEATH

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No..... ..... 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).....

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9. BIRTHPLACE (CITY OR TOWN).....

(STATE OR COUNTRY)

PARENTS

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....., 19..... .....

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from.....

....., 19....., to....., 19.....

that I last saw h..... alive on....., 19....., and th

death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ....yrs....mos....d

CONTRIBUTORY
(SECONDARY)

..... (duration) ....yrs....mos....d

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.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, sta
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| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19 |
|---|---|
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| | |

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WHITE PERMIT, WITH ONE BLANK, WILL BE ISSUED AS A PERMANENT RECORD