

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

11768

1. PLACE OF DEATH

County.....Buchanan..... Registration District No.....85
 Township..... Registration District No.....1001
 City.....St. Joseph..... (No. 920 Ridenbaugh Street)..... St. Ward)

File No.....
 Registered No. 479

2. FULL NAME Julia Nunning Byrne

(a) Residence. No. 920 Ridenbaugh Street 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 Female
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 OF Wm. C. Byrne

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 19, 1859

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
70	11	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House-wife

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

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) St. Joseph
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Henry Nunning

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

12. MAIDEN NAME OF MOTHER Johanna Alarndt

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

14. INFORMANT Mrs. Frank Flynn
 (Address) 920 Ridenbaugh St-St Joseph Mo.

15. FILED 15 1930
John S. Flynn
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 14 19 30

17. I HEREBY CERTIFY that I attended deceased from April 3 30 to April 4 30 that I last saw h. OT alive on April 4 30 and that death occurred, on the date stated above, at 5:05 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cholelithiasis
92 P
127 B

(duration) yrs. mos. ds. 12

CONTRIBUTORY (SECONDARY) Heart disease Valvular
Myocardial infarction (duration) yrs. mos. ds. unknown

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 Microscopic
 (Signed) John S. Flynn M. D.
Apr. 15 1930 (Address) St. Joseph 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 Mt. Olivet Cemetery
DATE OF BURIAL April 16 19 30

20. UNDERTAKER H. O. Sidenfaden
ADDRESS 1802 Union St

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.

WHITE PRINT WITH GRADING INK—THIS IS A PERMANENT RECORD

