

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

Do not use this space.

23402
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1. PLACE OF DEATH

County Wagoner
Township Wagoner
City Wagoner (No.)

Registration District No. 467
Primary Registration District No. 3024

File No.
Registered No.
St. Ward

2. FULL NAME

(a) Residence No. James Byford 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 12 1930

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Anna Byford

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 1, 1889

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 40 10 11

Drowning
Missouri River
1883 (duration) yrs. mos. da.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Knicker (b) General nature of industry, business, or establishment in which employed (or employer) Wheeler Bros (c) Name of employer Comp Co

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) Warren (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER John Byford

18. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

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

19. WHAT TEST CONFIRMED DIAGNOSIS (Signed) Edmund Sprack M.D.

12. MAIDEN NAME OF MOTHER Jane Couch

Address Wagoner, Wagoner Co

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

*State the DISEASE CAUSING DEATH, or if death from TOXIC or TRAUMA, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT (Address) Leanna Byford
Wagoner, Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wagoner Ky. DATE OF BURIAL July 16, 1930

15. July 14, 1930 S. W. Fordendall REGISTRAR

20. UNDERTAKER Wagoner ADDRESS Wagoner, Mo

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

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**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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.

1. PLACE OF DEATH.

County Lafayette Registration District No. 461 File No. 60
 Township Lexington Primary Registration District No. 3024 Registered No. _____
 City Lexington (No. _____) St. _____ Ward _____

2. FULL NAME

James Byford
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
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		
PARENTS	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)	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 12 19 30

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Drowning in Missouri river
accident
was working on river

CONTRIBUTORY (SECONDARY) 182
 (duration) yrs. mos. da.

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.

14. INFORMANT _____ (address) _____
 FILED July 14 30 G. W. Freed REGISTERAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
20. UNDERTAKER	ADDRESS

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