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

41447

1. PLACE OF DEATH
County: Lewis
Township: LaBelle
City: LaBelle (No. ..... St. ..... Ward)
Registration District No. 479
Primary Registration District No. 4288
File No. .....
Registered No. .....

2. FULL NAME: Elizabeth Byers
(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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Widow of Robt. L. Byers
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept 27 1836
7. AGE: Years 95 | Months 2 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer): Retired Housekeeper
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Macclesfield England
PARENTS
10. NAME OF FATHER: James S. Clayton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): England
12. MAIDEN NAME OF MOTHER: Elizabeth Jackson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): England
14. INFORMANT: Miss Agnes Byers
(Address): LaBelle Mo
15. FILED 12/14 1931 J. L. Bourne REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 12 1931
17. I HEREBY CERTIFY, That I attended deceased from December 10 1931 to December 12 1931 that I last saw her alive on December 12 1931, and that death occurred, on the date stated above, at 7:20 P.M.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
2 years ago she had a cerebral hemorrage after that was fed from dissel semiblind and bed to bed ridden (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Age (duration) ..... yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? at home
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical
(Signed) J. L. Carter M.D.
, 19 (Address) LaBelle, 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: LaBelle Cemetery | DATE OF BURIAL: 12/15 1931
20. UNDERTAKER: James T Coder | ADDRESS: LaBelle Mo

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 PAPER, WITH GRADING LINES IS A PERMANENT RECORD