

APR 9 1935

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County.....

Township.....

City *St Louis Mo.* (No. *City Hospital #2*)Registration District No. *791*Primary Registration District No. *1093*File No. *10578*Registered No. *2191*St. *Ward*

2. FULL NAME

(a) Residence, No. *1508-8-3-4* St. *23* Ward.

(Usual place of abode)

Length of residence in city or town where death occurred *20* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED, OR

Married

DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF

(OR) WIFE OF

Mollie Byrd

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

Feb. 8 - 1884

7. AGE

YEARS

51

MONTHS

-

DAYS

21/23

If LESS than 1

day, ... hrs.

or min.

8. Trade, profession, or particular

kind of work done, as spinner,

sawyer, bookkeeper, etc.

9. Industry or business in which

work was done, as silk mill,

saw mill, bank, etc.

10. Date deceased last worked at

this occupation (month and

year)

11. Total time (years)

spent in this

occupation

Nil

12. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

South Carolina

13. NAME

Isaac T Byrd

14. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ark.

15. MAIDEN NAME

Sarah Pitts

16. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ark.

17. INFORMANT

(ADDRESS)

Isaac T Byrd

18. BURIAL, CREMATION, OR REMOVAL

PLACE *East* DATE *Mar 7* 1935

19. UNDERTAKER

(ADDRESS)

J. S. Wade Undertaking Co.

20. FILED

MAR - 6 1935

J. S. Wade

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 1st* 1935

22. I HEREBY CERTIFY, That I attended deceased from

2 - 1 - 1935 to *3 - 1 - 1935*I last saw him alive on *3 - 1 - 1935* Death is saidto have occurred on the date stated above, at *11:55 AM*

The principal cause of death and related causes of importance were as follows:

*Hypertrophied Prostate*Date of onset *2-1-35*

Other contributory causes of importance:

137

Name of operation..... Date of.....

What test confirmed diagnosis? *Clinical* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) *J. Owen Blake, M. D.*(Address) *2945 - Lawton Blvd*

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

