

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.

NOV 26 1938

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

Do not use this space.

1. PLACE OF DEATH

County Shelby  
Township E. Dallas  
City \_\_\_\_\_ (No. \_\_\_\_\_) \_\_\_\_\_ (Ward \_\_\_\_\_)

Registration District No. 898  
Primary Registration District No. 6204

File No. 37124  
Registered No. 18

2. FULL NAME

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)  
Length of residence in city or town where death occurred 55 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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Barbara McCormack</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Mar 8, 1861</u>		
7. AGE <u>77</u>	YEARS <u>6</u>	MONTHS <u>26</u>
		DAYS <u>26</u>
		If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>farmer</u>
	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

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Shelby Co. Ky.</u>
	13. NAME <u>James C. Byrd</u>

MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ky.</u>
	15. MAIDEN NAME <u>Malinda Moses</u>

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ky.</u>
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17. INFORMANT (ADDRESS) <u>Mrs. Stewart</u>
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18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Pleasant Hill</u> DATE <u>10-6</u> 19 <u>38</u>
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19. UNDERTAKER (ADDRESS) <u>Kelly-Farrall</u>
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20. FILED <u>10-8</u> 19 <u>38</u> <u>Lester D. Good</u> Registrar
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MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 4, 1938

22. I HEREBY CERTIFY, That I attended deceased from 9-25 1938, to 9-25 1938. I last saw him alive on 9-25 1938. Death is said to have occurred on the date stated above, at 8:40 A.M.  
The principal cause of death and related causes of importance were as follows:

Arterio Sclerosis	Date of onset
Other contributory causes of importance: <u>77</u>	

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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 as a Beers  
(Signed) Seayman M. D.  
(Address) \_\_\_\_\_

RECEIVED

District Health Officer No. 6,

6-38-551

NOV 7 1938