

REC'D FEB 11 1939

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

3120  
Do not use this space.

1. PLACE OF DEATH 2

(a) County Mississippi Registration District No. 586

(b) Township City of Charleston Primary Registration District No. 3030

(c) City Charleston Mo (d) Street No. 1 Registered No. 7

(e) Length of residence in city or town where death occurred 3 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME Allie Lee Byars

(a) Residence, No. Deal St St.  (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Veelers Byars

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 14-1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

66 5 27

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc. Housewife

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH 8 AM

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 16 1939

22. I HEREBY CERTIFY That I attended deceased from Jan 15, 1939, to Jan 16, 1939

I last saw h.u. alive on Jan 15, 1939. Death is said to have occurred on the date stated above, at 8 a.m.

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

C. Myocarditis prob. 1 yr

Prim. Pneumonia following

Bronchitis 22

Date of onset 1 yr

Other contributory causes of importance:

C. Bronchitis (Prob. Tubercular)

C. Bronchial Asthma

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

What test confirmed diagnosis?..... 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? yes

If so, specify.....

(Signed) W. S. Love, M. D.745 (Address) Charleston, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn 1

FATHER

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 9

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 1

17. INFORMANT (ADDRESS) Paul Byars  
Charleston Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove Cemetery DATE 1-17 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Frank Fair Funeral Service  
Charleston Mo

20. FILED 1-18 1939 J. D. Brown  
Local Registrar.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**