

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

17141

Do not use this space.

1. PLACE OF DEATH **REC'D JUN 1 1939**
 (a) County..... **3** Registration District No..... **791**
 (b) Township..... **1** Primary Registration District No..... **1008** Registered No..... **4675**
 (c) City..... **Saint Louis** (d) Street No. **en route City Hosp. No. 2.** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **630 William Byrd**

(a) Residence, No. **2934 Clark Avenue** St. **18** (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 **Male** 4. COLOR OR RACE **Negro** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 3, 1870**

7. AGE YEARS **68** MONTHS **11** DAYS **18** If LESS than 1 day, hrs. or min.

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

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

10. Date deceased last worked at this occupation (month and year) ----- 11. Total time (years) spent in this occupation -----

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Franklin Kentucky**

MOTHER 13. NAME **Unavailable**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **11**

15. MAIDEN NAME **11**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **11**

17. INFORMANT (ADDRESS) **Margaret Sleets 2934 Clark Avenue**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Greenwood** DATE **5-24-39**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Charles J. Gates 4107-09 Finney Avenue**

20. FILED **MAY 23 1939** **J. B. Baker** Local Registrar

MEDICAL CERTIFICATE OF DEATH

no attending physician

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May 21st 1939**

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at **2:50 P.M.**

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

Cerebral Apoplexy.

Date of onset

Other contributory causes of importance:

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 **see above**

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? **1**

If so, specify _____ (Signed) **Joseph M. Moore**, M. D.
 (Address) **1300 Clark Avenue**

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.

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. 5522

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.