

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

44218

Registration District No. 657

Primary Registration District No. 4388

Registrar's No.

124

1. PLACE OF DEATH:

(a) County Peru (b) City or town Cauthersville (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution

(Specify whether

In this community. 3 yrs.
years, months or days)

3. (a) PRINT
FULL NAME

Bruis M. Byrd. 630

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex Female 5. Color or
race black

(a) Single, widowed, married,
divorced Married

6. (b) Name of husband or wife

6. (c) Age of husband or wife if
alive 30 years

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

18

6

21

hr.

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

housework

11. Industry or business

MOTHER FATHER

12. Name

Ann Sawwood

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

Mary Ann Robinson

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature

Tommy Byrd

(b) Address

Cauthersville MO

17. (a)

Burial

(b) Date thereof

12-26-39

(c) Place: burial or cremation

Morgan Ridge Cemetery

18. (a) Signature of funeral director

W. H. Smith

(b) Address

Cauthersville MO

19. (a)

Dec. 29, 1939

(b)

Ada Martin

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Peru
(c) City or town Cauthersville MO
(If outside city or town limits, write "RURAL.")

(d) Street No.

(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 23-39
year 1939 hour 10:00 minute P M.

21. I hereby certify that I attended the deceased from
12-23- 1939, to 12-23 1939
that I last saw her alive on 12-23- 1939
and that death occurred on the date and hour stated above.

Immediate cause of death

Stab Wounds

Duration

30 min

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Homicide
(b) Date of occurrence 12-23-39

(c) Where did injury occur? Cauthersville, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place

While at work? (Specify type of place) (e) Means of injury Knife

23. Signature V. J. Cozine (M. D. or other)

Address Cauthersville MO Date signed 12-26-39

RECEIVED

District Health Officer No. 3,

District File Number 140-807

Date Filed 1/19/40

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 Neel C. Dean

Licensed Embalmer No. 3941

P. O. Address Cynthiana, Mo.

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.