

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
JUN 10 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16558**
Registrar's No. **4036**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME James Lanier Byrd

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lucy 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased 8 (Month) 1 (Day) 1869 (Year)

8. AGE: Years 70 Months 9 Days 3 If less than one day hr. min.

9. Birthplace Charleston Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Lumber Dealer

11. Industry or business 0

12. Name Thomas Hayward Byrd

13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Lucy Nancy Hunter

15. Birthplace Sikeston Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Thomas Albert Byrd

(b) Address 505 Main Street-Charleston Mo

17. (a) Removal (b) Date thereof 5-6-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charleston Mo

18. (a) Signature of funeral director Alber H. Hoppe

(b) Address 4700 Washington

19. (a) MAY 6 1940 (b) Joe M. Park
(Date received local registrar) (Signature of embalmer)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi
(c) City or town Charleston NR
(If outside city or town limits, write "RURAL")
(d) Street No. 504 No Main Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4
year 1940 hour 5 minute 40 P. M.

21. I hereby certify that I attended the deceased from May
2, 1940, to May 4, 1940
that I last saw him alive on May 4, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Bronchopneumonia, at 6da
Pleurisy with effusion 6da

Due to Granulopenia, idiopathic

Due to Prostatic hypertrophy

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

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

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

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

23. Signature Joe M. Park (M. D. or other) MD

Address BARNES HOSPITAL Date signed 5-6-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

JUL 9 1944

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. 1122

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.