

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43810

LEO JAN 8 1941

State File No. _____

Registration District No. 184

Primary Registration District No. 200

Registrar's No. 2478

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Jennings
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Elms Convalescent Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Two Years
(Specify whether years, months or days)

In this community Twenty Five years
(Specify whether years, months or days) 3

3. (a) PRINT FULL NAME Agnes Byrne

8. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Dont Know
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>About 84</u>			<u>hr. _____ min.</u>

9. Birthplace Cincinnati Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

12. Name Patrick Byrne

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

14. Maiden name Dont Know

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

16. (a) Informant Virginia M. Smith

(b) Address 4442 S 38th St

17. (a) Burial (b) Date thereof 1/1/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cincinnati Ohio

18. (a) Signature of funeral director J. Thomas J. Jones

(b) Address 1519 South Grand Blvd

19. (a) DEC 30 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Jennings, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 2520 McLaran Avenue
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 29
year 1940 hour 3 minute 50 P.M.

21. I hereby certify that I attended the deceased from May
3 1940 to Dec 20 1940
that I last saw her alive on Dec 24 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Myocarditis

Due to _____

Due to _____

Other conditions Senility
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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) _____

(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)

(e) Means of injury _____

28. Signature [Signature] (M. D. or other) [Signature]

Address 6336 Clayton Road Date signed 12/30/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Thomas J. Fucar*

Licensed Embalmer No. *9197*

P. O. Address *Forest W*

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

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