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FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3678

State File No. _____

Registration District No. 644

Primary Registration District No. 5360

Registrar's No. 2

1. PLACE OF DEATH:
 (a) County Ozark - Thornfield
 (b) City or town Thornfield Milrion
(If outside city or town limits, write "RURAL" and name of township)
 (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 years
years, months or days

3. (a) PRINT FULL NAME Peter Allen Byrd
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex Male 5. Color or race white
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Nancy C. Byrd
 6. (c) Age of husband or wife if alive 72 years
 7. Birth date of deceased December 14 1858
(Month) (Day) (Year)

8. AGE: Years 82 Months — Days 21
 If less than one day _____ hr. _____ min.

9. Birthplace Hancock Co Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation minister

11. Industry or business _____

MOTHER FATHER {
 12. Name William Elliott Byrd
 13. Birthplace Tenn.
(City, town, or county) (State or foreign country)
 14. Maiden name Susan Templeton
 15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Nancy C. Byrd
 (b) Address Thornfield, Mo.

17. (a) Burial (b) Date thereof 1/7/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Thornfield Cemetery

18. (a) Signature of funeral director O. B. McClure
 (b) Address Gainesville, Mo.

19. (a) Jan 20-41 (b) Hattie G. Davis
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Ozark
 (c) City or town Thornfield
(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 January day 4th 1941
 year 1941 hour 4 minute a M.

21. I hereby certify that I attended the deceased from January 1, 1941, to January 3, 1941.
 that I last saw him alive on January 3, 1941.
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
 Duration 6 days

Due to _____

Due to _____

Other conditions asthma - senility
(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) _____

(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? _____

5:01 While at work? _____
(Specify type of place) (e) Means of injury

23. Signature M. J. Wiersman (M. D. or other) OO

Address Gainesville, Mo Date signed Jan 7 41

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

RECEIVED

District Health Officer No. 81

District File Number 241-295

Date Filed FEB 12 1941

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STATE OF ILLINOIS DEPARTMENT OF HEALTH

4 A.M. Jan. 4 .41

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3678

Registration District No. 649

Primary Registration District No. 5360

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ozark
(b) City or town Massion T.P.
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Peter allen Byrd

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 82 Months - Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 Jan day 4
year 1994 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Bronchial

Duration 7 days

Due to _____

Due to _____

Other conditions asthma - senility
(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) _____

(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 _____

23. Signature M. J. Hoevean (M. D. or other DD)

Address Saffordville, Mo Date signed 4/14/94

SUPPLEMENTAL

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

MOTHER FATHER

