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7-39  
X23159

FILED DEC 6 1941

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 4359

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Rural (Parma, Mo.)  
(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 \_\_\_\_\_  
years, months or days

3. (A) PRINT FULL NAME James Lee Byrn

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 Single

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased November 23, 1941  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	0	4	hr. _____ min.

9. Birthplace New Madrid County, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Johnnie Byrn

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

14. Maiden name Christine Dodd

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

16. (a) Informant Johnnie Byrn

(b) Address Parma, Mo. R. F. D. # 2

17. (a) Burial (b) Date thereof 11-28-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bernie Cemetery

18. (a) Signature of funeral director Blankenship-Strickland

(b) Address Bernie, Mo.

19. (a) 11-27-41 (b) Dr. C. W. [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. Parma, Mo. R. F. D. # 2  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 27  
year 1941 hour 4 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from 11-23-1941  
\_\_\_\_\_ 19\_\_\_\_, to 11-27-1941 19\_\_\_\_  
and that death occurred on the date and hour stated above.

that I last saw him alive on 11-27-1941

Immediate cause of death stenosis of esophagus Duration 4 days

Due to congenital defect of esophagus

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11611

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 S. E. Mitchell (M. D. or other M.D.)  
Address Malden Mo. Date signed 11-28-41

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

2000

072  
0  
0

504

RECEIVED

District Health Office No. 2

District File Number 1241-1600

Date Filed 12/4/41

**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.

*Body was not embalmed.*

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.**