

Registration District No. 819

Primary Registration District No. 4492

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Chaffee Turn
(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 20 yrs.
In this community 20 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Scott
(c) City or town Helita
(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? 0 years.

3. (a) PRINT FULL NAME Jessie Oliver Byrne
3. (b) If veteran name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 10
year 1942 hour 11 minute 30 A. M.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Martha Byrne
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased Oct. 3 1886
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2-10-42
19 to 2-10-42 19
that I last saw him alive on 2-10-42 19
and that death occurred on the date and hour stated above.

Immediate cause of death
Sudden Death Unknown
Natural Causes
Duration 30 Minutes

8. AGE: Years 55 Months 4 Days 8
If less than one day hr. min.

Due to Coronary Disease
Anginal Pectoris

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

Due to

10. Usual occupation Manager

Other conditions
(Include pregnancy within 3 months of death)

11. Industry or business General Store

Major findings:
Of operations

12. Name William A. Byrne

Of autopsy

13. Birthplace Scott County Mo
(City, town, or county) (State or foreign country)

14. Maiden name Helen J. Crockett

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

16. (a) Informant M. W. Byrne

(b) Address Bloomfield Mo.

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

(c) Place: burial or cremation North Antwerp - Bloomfield

18. (a) Signature of funeral director M. W. Byrne

(b) Address Chaffee, Mo.

19. (a) Feb. 12th (b) Mrs. A. H. Davis
(Date received local registrar) (Registrar's signature)

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?
(Specify type of place)
(e) Means of injury

23. Signature W. O. J... (M. D. or other)
Address Box 2 Bldg Chaffee Date signed 2/11/42
Mo

WRITE PAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD.

RECEIVED
District Health Office No. 2,
District File Number 342/340
Date Filed 3/9/41

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, ~~only~~.....
....., Registered Apprentice No.
working under my personal supervision.

Signed

Earl J. Smith

Licensed Embalmer No. 2676

P. O. Address Cape Girardeau

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.