

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32479**

ED OCT 2 - 1943

Registration District No. **317**

Primary Registration District No. **6076**

Registrar's No. **2206**

1. PLACE OF DEATH:

(a) County **ST LOUIS**
(b) City or town **SO. KINLOCH**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
OLD FOLKS NURSING HOME
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **01** years, months or days

3. (a) PRINT FULL NAME

MARY BYRD

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **COL** 6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **9 16 1873**
(Month) (Day) (Year)

8. AGE: Years **70** Months **0** Days **12** If less than one day hr. _____ min.

9. Birthplace **NASHVILLE TENN.**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business **none**

12. Name **ALLEN BYRD**

13. Birthplace **NASHVILLE TENN**
(City, town, or county) (State or foreign country)

14. Maiden name **UNKNOWN**

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

16. (a) Informant **ANNIE SOLDERS**

(b) Address **SO. KINLOCH**

17. (a) **Burial** (b) Date thereof **9-30-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cem**

18. (a) Signature of funeral director **J. H. Harrison**

(b) Address **2906 Benton Blvd**

19. (a) **SEP 30 1943** (b) **J. H. Harrison**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **ST. LOUIS**
(c) City or town **KINLOCH**
(If outside city or town limits, write "RURAL")
(d) Street No. **HUGO & GLENCO**
(If rural, give location)
(e) Citizen of foreign country? **NO.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **27** year **1943** hour **1 30** minute **12** M.

21. I hereby certify that I attended the deceased from **Sept - 20 - 43** to **Sept - 27 - 43** that I last saw her alive on **Sept - 27** and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia** Duration **7 days**

Due to _____

Due to _____

Other conditions **Petite Carcinoma**
(Include pregnancy within 3 months of death)

Major findings: Of operations **46 f**

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) (e) Means of injury _____

Signature **J. H. Harrison** (M. D. or other) **M.D.**

Address **2906 Benton Blvd** Date signed **9/29/43**

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.....

Ronald V. Atkins

Licensed Embalmer No. *2842*

P. O. Address. *3644 Finney Rd*

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.