S. No. 2
M—2-43
5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34115

FILED NOV 9 1943

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1117

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: R.F.D. # 6 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether In this community 6 hours years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ~~Atchison~~ Kansas (b) County Atchison

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

(d) Street No. 314 Craney St. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Lillian Byrne

3. (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 Married

6. (b) Name of husband or wife Thomas

6. (c) Age of husband or wife if alive 50 years

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

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Thomas Wright (Son)

(b) Address Atchison Kansas

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/12/43 (Month) (Day) (Year)

(c) Place: burial or cremation Cheriton, Iowa

18. (a) Signature of funeral director John E. Rupp

(b) Address 6054 Pryor Ave., City

19. (a) 10-12-43 (Date received local registrar) (b) Rose Hergoz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 11th year 1943 hour 1 minute 45 A.M.

21. I hereby certify that I ~~attended~~ viewed the deceased ~~from~~ on Oct. 11th, 1943, to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Basal Skull Fracture	1 day
Fracture of neck	
Due to Fracture ribs on left side of Ches. Fracture of	6
Due to left wrist and right for arm.	10
Other conditions (Include pregnancy within 3 months of death) Woman was riding in an automobile when it	23
Major findings: Of operations Collided with a train on Lake Road Crossing	
Of autopsy No: Near Memorial highway	

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) Accident

(b) Date of occurrence Oct 11 - 1943. 131

(c) Where did injury occur? St Joseph (City or town) Buch (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway Mtr by County (Specify type of place)

While at work? No (e) Means of injury Auto train Corona

23. Signature H F Mundy (M.D. or other)

Address 404 So 3d St. St Joseph, Mo Date signed 10/11/43

1235

(Licensed Embalmer's Statement on Reverse Side)

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.....John E. Rupp

Licensed Embalmer No.....98

P. O. Address.....St. Joseph, Mo

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.