

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16220

FILED JUN 9 1944 318

Registration District No. Primary Registration District No. 1003

State File No.

Registrar's No. 5090

1. PLACE OF DEATH:

(a) County Mo
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
716 S. 4th St
(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 Byrd
3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex M 5. Color or race negro 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. years
7. Birth date of deceased unknown
(Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

12. Name unknown
13. Birthplace unknown (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 Mildred Roberson
(b) Address 716 S 4th St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 3 44 (Month) (Day) (Year)
(c) Place: burial or cremation Capevale

18. (a) Signature of funeral director A. H. Burtis
(b) Address 1600 S 3rd St

19. (a) (Date received by registrar) JUN 9 1944 (b) (Registrar's signature) J. F. Burtis

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 716 S 4th (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country. 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29 year 1944 hour 10 minute A.M.
21. I hereby certify that I attended the deceased from 5-1-44 to 5-15-44, 19, that I last saw him alive on 5-15-44, 19, and that death occurred on the date and hour stated above.
Immediate cause of death myocarditis; chronic (Duration)

Due to 9th
Due to 9th
Other conditions (Include pregnancy within 3 months of death)
Major findings: none
Of operations none
Of autopsy none

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?

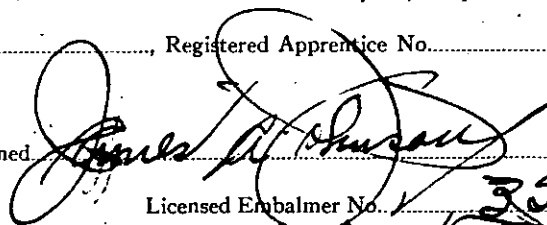
While at work? (Specify type of place) (c) Means of injury 0

23. Signature St. Valley (M. D. or other) Address 740 S 4th Date signed 6/2/44

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. 3522

P. O. Address 3506 Franklin

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.