No. 2
5-42
17-39
X32873

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

16220
State File No.

FILED JUN 9 1944 318
Registration District No.

Primary Registration District No. 1003

Registrar's No. 5090

1. PLACE OF DEATH:

(a) County St Louis 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. 4. 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)

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 4 St
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME James I 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 W

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 abt - 50 | Months — | Days — | If less than one day hr. min.

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

10. Usual occupation Labor

11. Industry or business Labor

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 Mulder Robeson

(b) Address 716 S 4 St

17. (a) Burial (b) Date thereof 6 3 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakdale

18. (a) Signature of funeral director O. H. Burks

(b) Address 1600 S 2nd St

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

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, 19..., 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

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature E. H. Wallen M.D. (M. D. or other)

Address 740 S 4 St. Date signed 6/2/44

(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 James M. Duncan

Licensed Embalmer No. 3522

P. O. Address 35 Oak Grandville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.