No. 2
9-3-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 16 1945

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6527

Registration District No. 184 Primary Registration District No. 3058 Registrar's No. 412

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Convalescing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 years (Specify whether)
In this community 58 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Linn
(c) City or town LaClede
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location) 2
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ARTHUR SYLVESTER BYRD
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Mrs Carolyn R. Byrd
6. (c) Age of husband or wife if alive Dead years
7. Birth date of deceased October 7, 1850
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
94	3	7	hr. min.

9. Birthplace Rockingham Co. (City, town, or county) Virginia (State or foreign country)
10. Usual occupation Mill wright - Retired
11. Industry or business

MOTHER FATHER
12. Name John M. Byrd
13. Birthplace Not known (City, town, or county) (State or foreign country)
14. Maiden name Not known
15. Birthplace Not known (City, town, or county) (State or foreign country)

16. (a) Informant John E Byrd
(b) Address Linneus Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation LaClede, Mo. Cem.
18. (a) Signature of funeral director Not known
(b) Address LaClede, Linn Co. Mo.
19. (a) 1-12-1945 (Date received local registrar) (b) W. W. Canan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 11
year 1945 hour 4 minute A. M.
21. I hereby certify that I attended the deceased from 12-25-, 1944 to Jan 11, 1945
that I last saw him alive on Jan 7, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute Myocarditis	10 Days
Due to Fractured Hip	2 Weeks
Due to	

Other conditions (Include pregnancy within 3 months of death) ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings:
Of operations
Of autopsy

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) N/A
(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
23. Signature W. B. Sampson M. D. or other)
Address Brookfield Mo Date signed 1-12-45

456 (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 me

, Registered Apprentice No. 2876

working under my personal supervision.

Signed W. G. Sharrow

Licensed Embalmer No. 2876

P. O. Address Caribou, Me

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

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

S. No. 2B
OM—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 164 Primary Registration District No. 3038 Registrar's No. 412

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Brookfield

(If outside city or town limits, write "RURAL" and name of township)

(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 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Arthur S. Byrd

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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 Oct (Month) 7 (Day) 1850 (Year)

8. AGE: Years 94 Months 3 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 day
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , 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	
Due to	
Due to Arterio Sclerosis	2 yrs
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 12-21-1944
(c) Where did injury occur? Brookfield (City or town) Linn (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? At Home - Fall. (Specify type of place)
While at work? No (e) Means of injury Fracture Hip - Right

23. Signature W. B. Simpson (M. D. or other) MD
Address Brookfield Mo Date signed 2/20/45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

6527