

Form No. 2
Bureau of the Census
Rev. 5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 11 1945

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **10589**
Registrar's No. **737**

Registration District No. **317**

Primary Registration District No. **3068**

16
5
3

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

1. PLACE OF DEATH:

(a) County Maplewood St. Louis Co

(b) City or town 3312 Cambridge Ave
(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)

In this community about 20 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME William T. Byrnes

3. (b) If veteran, American **3. (c) Social Security**
Spanish War No. _____

4. Sex m **5. Color or race** w

6. (a) Single, widowed, married, 2 divorced w
6. (b) Name of husband or wife Mary Alice Scannell deceased
6. (c) Age of husband or wife if _____ years

7. Birth date of deceased. October 1 1871
(Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 9
If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Postal Clerk

11. Industry or business U. S. Government

12. Name Thos. Byrnes

13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name Cliria Kennedy 11

15. Birthplace Ireland 11
(City, town, or county) (State or foreign country)

16. (a) Informant Miss M. Maguire

(b) Address 3312 Cambridge

17. (a) burial **(b) Date thereof** Mar 13 '45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grafton Ill

18. (a) Signature of funeral director Mrs. Croghan

(b) Address 7146 Manchester

19. (a) Date received local registrar MAP 21 1945 **(b) Signature** E. B. [Signature]
(Date received local registrar) (Register's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis 96

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

(d) Street No. 7320 Lyndon
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10
year 1945 hour 5 a.m. minute _____ M.

21. I hereby certify that I attended the deceased from Sept 10, 44
_____, 19, to 3-10-45, 19, _____

that I last saw him alive on 3-9-45, 19, _____
and that death occurred on the date and hour stated above.

Immediate cause of death uremia 4 wks
Duration

Due to Chr. nephritis 5 yrs
arterio sclerosis 8 years
Due to Myocarditis 5 yrs

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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)

(e) Means of injury _____

Signature E. B. Breckenridge M.D. (M.D. or other)

Address Maplewood Mo Date signed 3-12-45

709

(Licensed Embalmer's Statement on Reverse Side)

JUN 22 1945

FEB 20 1945

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..... *Albert G. Hoffer*

Licensed Embalmer No. 2971.....

P. O. Address.....

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.