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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 27 1945

Registration District No. 1318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 11055

Registrar's No. 3511

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: 1319 Sidney Str.
(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 Mo. (b) County

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

(d) Street No. 1319 Sidney Str.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME James Byrne

3. (b) If veteran, name war ---

3. (c) Social Security No. ----

4. Sex Male

5. Color or race Wht.

6. (a) Single, widowed, married, divorced Wid.

6. (b) Name of husband or wife Emma Byrnes

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

7. Birth date of deceased Aug. (Month) 15 (Day) 1874 (Year)

8. AGE: Years 70 Months 8 Days 3 If less than one day hr. min.

9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Charles Byrne

13. Birthplace Ireland (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 Margaret Mager

(b) Address 1801 Lami Str.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/45 (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope

18. (a) Signature of funeral director Wm. C. Maydell

(b) Address 1926 Allen Ave.

19. (a) APR 20 1945 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18 year 1945 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from April 9th 1945, 19, to April 18th, 1945, 19, that I last saw him alive on April 18th, 1945, 19, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis ?

Due to Chronic Cardiac Valvular Disease (Mitral Stenosis)

Due to Chronic Myocardial Disease

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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

23. Signature Paul B. Weble (M. D. or other)

Address 1915 Sidney St Date signed 4/19/45

(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.....,

working under my personal supervision.

Signed L. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 Allen ave

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.