

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

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34317

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 288

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
313 E. Lima Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 35 yrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME JOHN THOMAS BYRD

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M, race N
5. Color or race N
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Era Mae Byrd
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 3 1 1870
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 22
If less than one day hr. min.

9. Birthplace Pettis Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Unknown

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 Oscar Byrd

(b) Address Sedalia Mo

17. (a) Burial (b) Date thereof 10-27-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill, Sedalia Mo

18. (a) Signature of funeral director T. D. Ferguson

(b) Address Sedalia Mo

19. (a) 11-2-45 (b) J. D. Campbell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis
(c) City or town Sedalia
(If outside city or town limits, write "RURAL")
(d) Street No. 313 E. Lima Ave
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23
year 1945 hour 10 minute P.M.

21. I hereby certify that I attended the deceased from 10-23-1945 to 10-23-1945
that I last saw him alive on 10-23-1945
and that death occurred on the date and hour stated above.

Immediate cause of death Duration

Acute Coronary Occlusion

Due to Hypertension

Due to Nephritis Chronic

Other conditions (Include pregnancy within 3 months of death) 1316

Major findings:
Of operations

Of autopsy

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

23. Signature A. R. Madrox (M. D. or other) MD

Address 416 E. W. Main Date signed 10-25-45

OCT 28 1947

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 11-2-45

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

F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address Sedalia

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.