

S. No. 2
M-5-43
5-17-39
I X36671

FILED MAR 20 1946
Registration District No. **378**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
1417 Farrar St. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Cora Byrns Sibille

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female **5. Color or race** White

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

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased. April 6, 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>11</u>	<u>2</u>	hr. _____ min. _____

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

10. Usual occupation. At home

MOTHER FATHER

11. Industry or business _____

12. Name. Michael Byrns

13. Birthplace. Unknown Canada
(City, town, or county) (State or foreign country)

14. Maiden name. Anna Jessup

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

16. (a) Informant. Alvin C. Sibille

(b) Address. 1417 Farrar St.

17. (a) Burial _____ **(b) Date thereof.** 3/12/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Calvary Cemetery

18. (a) Signature of funeral director. Math Hermann & Son
(b) Address. 2161 East Fair Ave

19. (a) MAR 11 1946 J. F. Bredbeck
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 1417 Farrar St.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8th
year 1946 hour 5:30 AM minute _____ M.

21. I hereby certify that I attended the deceased from March 5 4/6 to March 8 4/6
that I last saw her alive on March 8 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis 6-1-45

Due to Arteriosclerosis 6-1-45

Due to _____

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? _____

While at work? _____ (Specify type of place) _____
(e) Means of injury _____

23. Signature Remond Byrns M.D. or other _____
Address 3802 N. Grand Bl. signed 3-9-46

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 William G. Buckholz
Licensed Embalmer No. 2110
P. O. Address St. Louis, Mo

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.