

FILED JUN 11 1946

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 316

Primary Registration District No. 4462

Registrar's No. 167

1. PLACE OF DEATH:

(a) County St. Francois
 (b) City or town Elvins
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____ years, months or days) years

3. (a) PRINT FULL NAME Bart Byington
 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, or married
 6. (b) Name of husband or wife Lillian Byington (c) Age of husband or wife if alive 43 years
 7. Birth date of deceased July 15 1878 (Month) (Day) (Year)

8. AGE: Years 67 Months 9 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace St. Francois Co. MO (City, town, or county) (State or foreign country)

10. Usual occupation retired

11. Industry or business _____

MOTHER FATHER

12. Name Elton Byington
 13. Birthplace Mo (City, town, or county) (State or foreign country)
 14. Maiden name Bernice Rudolph
 15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant Lillian Byington
 (b) Address Elvins Mo

17. (a) Burial (b) Date thereof 5-2-46
 (Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Barbview
 (b) Address Baldwell Bros

19. (a) 5-20-46 (b) Ether Rudolph
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
 (c) City or town Elvins (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 1
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 30th day April
 year 1946 hour 9 AM minute _____ M.

21. I hereby certify that I attended the deceased from June 4/3, 1946, to April 30, 1946
 that I last saw him alive on April 26, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death arterio-sclerotic degeneration & hypertensive heart
 Due to hypertension

Due to _____
 Other conditions cardiac enlargement
 (Include symptoms within months of death) hypertension

Major findings: _____
 Of operations _____
 Of autopsy g. H.

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) _____
 Means of injury _____
 23. Signature W. O. Scarbe (M. D. or other) _____
 Address Deeridge, Mo. Date signed 5-17-46

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. Y

District File Number 646-223

Date Filed 6-10-46

JUN 18 1946

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 W.A. Baldwin

Licensed Embalmer No. 3317

P. O. Address Flat River

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.

Registration District No. 316

Primary Registration District No. 4462

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Clown
(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 _____ years, months or days

3. (a) PRINT FULL NAME Sgt. Byington

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 M

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

7. Birth date of deceased July (Month) 29 (Day) 1944 (Year)

8. AGE: Years 67 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace St. Francois County, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-24-46 (b) Ether Rudloff (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1944 Hour _____ minute _____ M. 30

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____

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.

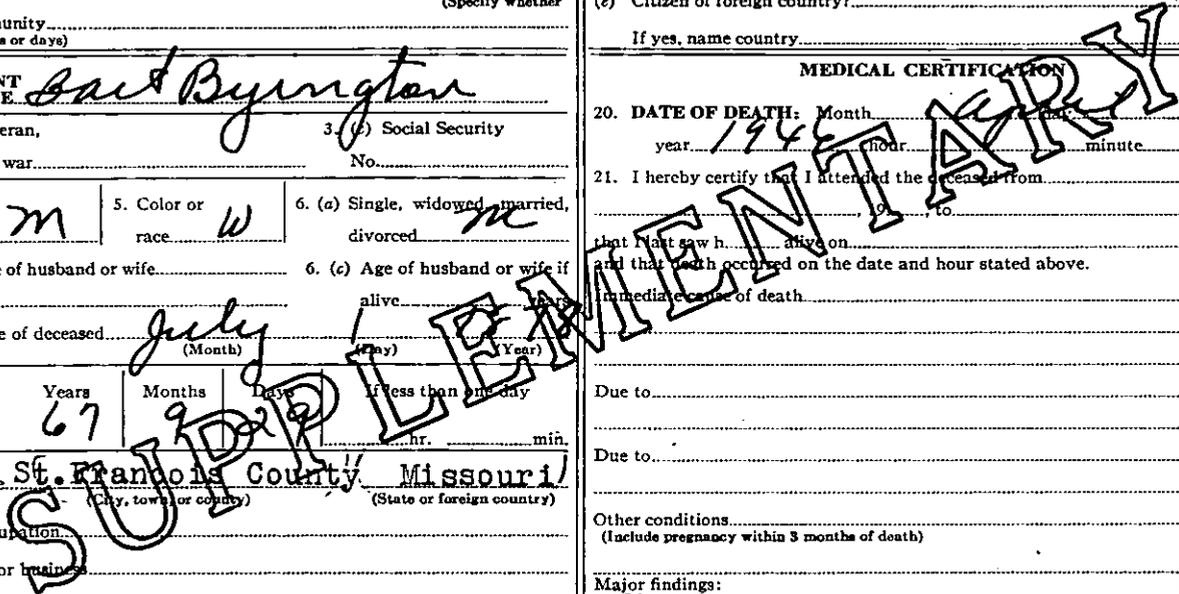
22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(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 _____ (M. D. or other)

Address _____ Date signed _____



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

3880

17800