

No. 2
12-45
-17-39

X47070

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED SEP 23 1946 STANDARD CERTIFICATE OF DEATH

State File No. **32406**
Registrar's No. **61**

Registration District No. **333** Primary Registration District No. **3074**

1. PLACE OF DEATH:
(a) County **Scott**
(b) City or town **Sikeston**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Home Delmar St**
(If not in hospital or institution; write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **50 years** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri**, (b) County **Scott** 100
(c) City or town **Sikeston** 5
(If outside city or town limits, write "RURAL") 2
(d) Street No. **Delmar** 0
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **THOMAS M. BYRD**
(b) If veteran, name war **✓**
(c) Social Security No. **✓**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **27**
year **1946** hour **5** minute _____ P.M.

4. Sex **Male** (5. Color or race **White**)
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **Oct 16 1859**
(Month) (Day) (Year)

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

8. AGE: Years Months Days If less than one day
86 9 11 hr. _____ min.

Immediate cause of death **apoplexy** Duration _____

9. Birthplace **Mc Kenzie Tenn**
(City, town, or county) (State or foreign country)

Due to _____
Due to _____

10. Usual occupation **Retired**

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

MOTHER FATHER

11. Industry or business _____
12. Name **James Byrd**
13. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____
Of autopsy _____

16. (a) Informant **Taylor Hue Hamby**
(b) Address **Sikeston, Mo**

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

17. (a) **Burial** (b) Date thereof **7-29-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

18. (a) Signature of funeral director **Taylor Samuel Hamby**
(b) Address **Sikeston, Mo**
19. (a) **9-16-46** (b) **Mrs J. Ferry**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **J. S. Henstead** (M. D. or other) _____
Address **Sikeston Mo.** Date signed **Aug 3-46**

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

RECEIVED

District Health Office No. 2,

District File Number 946-1141

Date Filed 9-21-46

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 *W. Brown*.....

Licensed Embalmer No. 4399.....

P. O. Address Poplar Bluff.....

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.