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DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC HEALTH
FILED MAR 8 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11749
Registrar's No. 670

Registration District No. 317 Primary Registration District No. 3063

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(c) Name of hospital or institution: St. Louis County Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 Days
In this community 9 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Louis
(c) City or town Le May
(d) Street No. 9908 Meadows
(e) Citizen of foreign country? (Yes or No) No
If yes, name country _____

3. (a) PRINT FULL NAME Pat Byrnes
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M D 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rose Brown Byrnes 6. (c) Age of husband or wife if alive 3 years
7. Birth date of deceased 7 3 1868
(Month) (Day) (Year)

8. AGE: Years 78 Months 8 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace Ireland (City, town, or county) (State or foreign country) 4

10. Usual occupation None

11. Industry or business NONE

12. Name Thomas Byrnes 13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name KATE BYRNES 15. Birthplace IRELAND
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ellen Dale (b) Address ST. LOUIS CO, MO

17. (a) BURIAL (b) Date thereof 3-17-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BARNHART, MO. (MO FOR)

18. (a) Signature of funeral director FENDLER UND CO
(b) Address 7420 MICHIGAN

19. (a) 3-18-47 (b) Ellen Dale
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION -

20. DATE OF DEATH: Month 3 day 14
year 1947 hour 2 minute 25 P.M.

21. I hereby certify that I attended the deceased from 3-5-47
to 3-14, 1947

that I last saw him alive on 3-14, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease Duration _____

Due to 930

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) (b) Manner of injury _____

23. Signature Ellen Dale (M. D. or other) _____
Address 601 Brentwood Blvd Date signed 3/14/47

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

MOTHER FATHER

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 *Oliver E. Sander*
Licensed Embalmer No. *4548*
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.