

No. 2
12-4-3
17-39
K47070

FILED APR 26 1948

Registration District No. 184

Primary Registration District No. 3038

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(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 3 Months (Specify whether years, months or days)
In this community 3 Months

3. (a) PRINT FULL NAME Sylvester B. Byrd

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

4. Sex M 2 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased August 19 1907
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>7</u>	<u>17</u>	_____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name W.M. Byrd

13. Birthplace Shelbina, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Jessie B. Burns

15. Birthplace Monroe City, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Jessie B. Byrd

(b) Address 222 W. Canal St. (Brookfield)

17. (a) Burial (b) Date thereof April 8, 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rosehill Cemetery

18. (a) Signature of funeral director Bowden Funeral Home

(b) Address Brookfield, Mo.

19. (a) 4-10-48 (b) W.B. Crews
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58
(c) City or town Brookfield 1
(If outside city or town limits, write "RURAL") 2
(d) Street No. 222 W. Canal 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6
year 1948 hour 6 minute 12 P.M.

21. I hereby certify that I attended the deceased from March 2, 1948 to April 5, 1948
that I last saw him alive on April 5, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 2 yrs

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 0

23. Signature Roy B. Haley (M. D. or other) M. D.

Address Brookfield Mo. Date signed 4-7-48

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

MOTHER FATHER

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *James B. McClelland*
Licensed Embalmer No. *4230*
P. O. Address..... *Brookfield*

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. 184

Primary Registration District No. 5038

1. PLACE OF DEATH:

(a) County Living Brookfield
 (b) City or town Living Brookfield
(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)

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.....

3. (a) PRINT FULL NAME

Syvester B. Byrd

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

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years 40 Months 7 Days 19 (if less than one day)
hr. min.

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

10. Usual occupation General laborer

11. Industry or business Penitentiary

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.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b).....
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1947 hour..... minute..... M.

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.....

Duration

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.....

SUPPLEMENTARY

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

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