

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

35335

State File No.

Registrar's No.

FILED OCT 28 1948
Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

- (a) County Stoddard
(b) City or town E. over - Rural - back up
(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 MAXWELL CHESTER BYRD

3. (b) If veteran, name war World War I 3. (c) Social Security No. 272-22-5119

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Grace Byrd 6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased April 21 1897
(Month) (Day) (Year)

8. AGE: Years 51 Months 5 Days 17 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business

12. Name unknown
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Grace Byrd
(b) Address Cape Girardeau, Mo.
17. (a) Burial (b) Date thereof 10-20-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Dexter Cemetery

18. (a) Signature of funeral director Strickland-Rainey
(b) Address Dexter, Missouri

19. (a) 10-22-48 (b) Delma J. Jackson
(Date received local registrar) (Registrar's signature)

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County Stoddard
(c) City or town near Dexter
(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 Oct day 18
year 1948 hour 12 minute P M.

21. I hereby certify that I attended the deceased from
that I last saw h. alive on
and that death occurred on the date and hour stated above.

Immediate cause of death heard diastolic to wit: myocarditis

Due to
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause of 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 St. Lawrence (M. or other) Ca.
Address Dexter, Mo. Date signed Oct. 18, 48

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

MOTHER FATHER

RECEIVED

District Health Office No. 2

District No. 1048-1389

Date 10-27-48

10-27-48

NOV 12 1948

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 _____

Licensed Embalmer No. 3419

P. O. Address _____

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.