

S. No. 304
OM-10-47
ev. 5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37946**
Registrar's No. **10117**

FILED DEC 2 1948
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. John's Hospital
(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 Elizabeth Byrne

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife James Byrne

6. (c) Age of husband or wife if alive 18 5/8 years

7. Birth date of deceased November 23, 1859
(Month) (Day) (Year)

8. AGE: 88 Years 11 Months 26 Days
If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Dougherty

{ 13. Birthplace Ireland
(City, town, or county) (State or foreign country)

{ 14. Maiden name Esther English

{ 15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. James Byrne

(b) Address 717 Radclife

17. (a) Burial (b) Date thereof 11-23-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery Southern Funeral Home

18. (a) Signature of funeral director _____

(b) Address 6322 S. Grand Blvd

19. (a) NOV 22 1948 J. B. Lassala
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4976 Wabada
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 19th
year 1948 hour 5 minute 30 p.m.

21. I hereby certify that I attended the deceased from 3-5, 1948, to 11-19, 1948
that I last saw her alive on 11-19, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease & old. mitral stenosis & endocarditis.

Duration 1 1/2 yrs

Due to _____

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy as above

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) no

(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 no

23. Signature John J. Hammond (M. D. or other) M.D.

Address 6322 S. Grand St. Louis Mo Date signed 11/20/48

DR. JOHN J. HAMMOND
MISSOURI, DECEMBER 31, 1956.
230 70 S. CAT

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..... 3657

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.