

FILED SEP 1 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29119

BIRTH NO. _____		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 3074		Registrar's No. 126	
1. PLACE OF DEATH a. CITY Scott				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Scott			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston			
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Delta Comm. Hospital				d. STREET ADDRESS (If rural, give location) 801(rear) Delmar			
3. NAME OF DECEASED (Type or Print)		a. (First) James		b. (Middle) Edgar		c. (Last) Byrd	
4. DATE OF DEATH		a. (Month) Aug.		b. (Day) 14,		c. (Year) 1950	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 12, 1887	9. AGE (In years last birthday) 63	10. IF UNDER 1 YEAR Days 2	11. IF UNDER 24 HRS. Hours 2	12. IF UNDER 1 MIN. Min. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Miss. County, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Thomas M. Byrd(dec)		13b. MOTHER'S MAIDEN NAME Ludie Wilson.(dec)		14. NAME OF HUSBAND OR WIFE Lulu Belle Byrd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. C. L. Hamby, Sikeston, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage, cerebral ANTECEDENT CAUSES (b) Arteriosclerosis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 3 days Long Standing	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES ☐ NO ☒	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-11 , 19 50 , to 8-14 , 19 50 , that I last saw the deceased alive on 8-14 , 19 50 , and that death occurred at 3:45 A m., from the causes and on the date stated above.							
23a. SIGNATURE AS Hester		(Degree or title) M.D.		23b. ADDRESS Sikeston Mo		23c. DATE SIGNED 8-15-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-16-50		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) Sikeston New Madrid Mo	
DATE REC'D BY LOCAL REG. Aug 23-50		REGISTRAR'S SIGNATURE Mrs. Ella Hester		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Taylor Funeral Home, Sikeston Mo			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED **AUG 28 195**

SCOTT COUNTY HEALTH CE

CO. FILE NO. 850-

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

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4685

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.