

STANDARD CERTIFICATE OF DEATH

FILED DEC 12 1950

BIRTH NO. REG. DIST. NO. 221 PRIMARY REG. DIST. NO. 5793 Registrar's No. 18-

689

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

1. PLACE OF DEATH a. COUNTY MONTEAU		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY MONTEAU	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL LINN		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL LINN	
c. LENGTH OF STAY (in this place) 26 yr		d. STREET ADDRESS (If rural, give location) JAMESTOWN MO	
d. FULL NAME OF HOSPITAL OR INSTITUTION JAMESTOWN MO			

3. NAME OF DECEASED a. (First) LILLIAN b. (Middle) MAY c. (Last) BYZENDINE			4. DATE OF DEATH (Month) (Day) (Year) DEC. 3-1950		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAY 1-1897	9. AGE (In years last birthday) 53	10. IF UNDER 1 YEAR Months	11. IF UNDER 12 HRS. Hours	12. IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? U S
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13a. FATHER'S NAME THOMAS CHILDRES	13b. MOTHER'S MAIDEN NAME MARTHA BYZENDINE	14. NAME OF HUSBAND OR WIFE CHARLES BYZENDINE (DEAD)
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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 Eunice Byzendine Jamestown	18. ADDRESS JAMESTOWN
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____	
		DUE TO (c) _____		DUE TO (c) _____	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4:20	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) RURAL LINN MONTEAU MO
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12/3**, 19**50**, to **12/3**, 19**50**, that I last saw the deceased alive on **12/3**, 19**50**, and that death occurred at **3:20** m., from the causes and on the date stated above.

23a. SIGNATURE J. H. Brown (Degree or title)	23b. ADDRESS California	23c. DATE SIGNED 12/4/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-5-1950	24c. NAME OF CEMETERY OR CREMATORY MT ZION CEM.	24d. LOCATION (City, town, or county) (State) NEAR JAMESTOWN MO
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DATE REC'D BY LOCAL REG. Dec 7-1950	REGISTRAR'S SIGNATURE Gada Bro... 199	25. FUNERAL DIRECTOR'S SIGNATURE ALBERT HORNBECK	ADDRESS BATTLE HOME
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RECEIVED

12/11/52

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 12-11-52

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 E. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Prairie Home 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.