

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

25634

6339

FILED JUL 22 1952

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY 2269			
b. CITY OR TOWN St Louis 3		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute To City Hospital				d. STREET ADDRESS (If rural, give location) 26 1946 No 11th St.			
3. NAME OF DECEASED (Type or Print) a. (First) James		b. (Middle) E		c. (Last) Byrd		4. DATE OF DEATH (Month) (Day) (Year) 6-29-1952	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 3-3-1923	
9. AGE (In years last birthday) 29		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRIVER		10b. KIND OF BUSINESS OR INDUSTRY Taxi		11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo	
12. CITIZEN OF WHAT COUNTRY? usa		13a. FATHER'S NAME Richard Byrd		13b. MOTHER'S MAIDEN NAME Edith Coates		14. NAME OF HUSBAND OR WIFE Alice Byrd St Louis Mo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT'S SIGNATURE OR NAME Eve Coates		ADDRESS 1946-No 11 St Louis 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, asthma, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heat Stroke ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION				20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? no E9319			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:17 P. m., from the causes and on the date stated above. 46							
23a. SIGNATURE (Degree or title) Patricia Taylor Corcoran				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 7-2-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE July 2, 1952		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) St Louis County Mo	
DATE REC'D BY LOCAL REG. JUL 2 1952		REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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

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. _____

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.