

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38279

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1204

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>		
b. CITY OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>30 Yrs.</u>	c. CITY OR TOWN <u>St. Joseph</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wyatt Park Nursing Home</u> <u>2705 Lafayette St.</u>			d. STREET ADDRESS (If rural, give location) <u>919 Mitchell Ave.</u>		

3. NAME OF DECEASED (Type or Print)	a. (First) <u>CLIFFORD</u>	b. (Middle) <u>H.</u>	c. (Last) <u>BYRKIT</u>	4. DATE OF DEATH (Month) (Day) (Year)	<u>Nov. 17, 1953</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 12/1878</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 28 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Fairfield, Nebr.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Martin Byrkit</u>	13b. MOTHER'S MAIDEN NAME <u>Georgia Farr</u>	14. NAME OF HUSBAND OR WIFE <u>Maudie Byrkit</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>498-24-6184</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Willis Kemper</u>	ADDRESS <u>Torrington, Wyo.</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Multiple Cerebral Hemorrhage with right hemiplegia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senile Debility</u>		unknown	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>331 X</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 10-8, 1953, to 11-17, 1953, that I last saw the deceased alive on 11-16-53, 1953, and that death occurred at 5:40 PM from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>H. J. Mundy M.D.</u>	23b. ADDRESS <u>2801 Sacramento St. Joseph, Mo.</u>	23c. DATE SIGNED <u>11-18-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Nov. 19/53</u>	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) <u>Fairfield Nebr.</u>
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DATE REC'D BY LOCAL REG. <u>Nov 23, 1953</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Barry Funeral Home, St. Joseph Mo.</u>	ADDRESS _____
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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 _____

Victor J. Barry

Licensed Embalmer No. *4212*

P. O. Address *St Joseph 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.