

FILED MAR 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5832

BIRTH NO. 124		REG. DIST. NO. 316		PRIMARY REG. DIST. NO. 3059		Registrar's No. 50	
1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bonne Terre</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Flat River</u>		d. STREET ADDRESS (If rural, give location) <u>3 Callegas St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp.</u>				0941			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Cora</u>		b. (Middle) <u>Lee</u>		c. (Last) <u>Byrd</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 11 1954</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 11-1894</u>	
9. AGE (In years last birthday) <u>69</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Clinton, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Mr. William B. Thurman</u>		13b. MOTHER'S MAIDEN NAME <u>Alice M. Burch</u>		14. NAME OF HUSBAND OR WIFE <u>Mr. George Byrd</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. George Byrd 3 Callegas St. Flat River, Mo.</u>			
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) <u>Cardiac insufficiency and failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic myocarditis, arrhythmia fibrillation</u> DUE TO (c) <u>Unilateral arterial sclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>3 years</u> <u>total years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4-2-21</u>				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 <u>8/14</u> , 19 <u>49</u> , to <u>2/9</u> , 19 <u>54</u> ; that I last saw the deceased alive on <u>2/9</u> , 19 <u>54</u> , and that death occurred at <u>7 P. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Paul Z. Jones MD</u>				23b. ADDRESS <u>Flat River, Mo</u>		23c. DATE SIGNED <u>2/19/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		24b. DATE <u>Feb. 14-1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Francois Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>Bonne Terre Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 19, 1954</u>		REGISTRAR'S SIGNATURE <u>Ethel Giddings</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Alvin W. Hood - 303 Callegas St. Flat River, Mo</u>			

(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. 2780

P. O. Address 33 Crane St. New York

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.