

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17080

State File No.

BIRTH NO. 24951-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4144

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Jefferson	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. LENGTH OF STAY (In this place) D.O.A.		c. CITY OR TOWN Imperial	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Anthony Hospital		e. STREET ADDRESS (If rural, give location) Rt 2, Box 245			

3. NAME OF DECEASED (Type or Print)	a. (First) Bryce	b. (Middle) Barry	c. (Last) Bird	4. DATE OF DEATH (Month) (Day) (Year) May 7th 1954
-------------------------------------	----------------------------	-----------------------------	--------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child	8. DATE OF BIRTH April 23 1954	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 0	IF UNDER 1 YEAR Days 16	IF UNDER 24 HRS. Hours 	IF UNDER 24 HRS. Min.
-----------------------	----------------------------------	--	--	---	---------------------------------------	--------------------------------------	--------------------------------------	-------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) St Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	--	---

13a. FATHER'S NAME James A. Bird	13b. MOTHER'S MAIDEN NAME Myrtle Cochran	14. NAME OF HUSBAND OR WIFE *****
--	--	---

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. None	17. INFORMANT'S SIGNATURE OR NAME Mr James Bird	ADDRESS Rt 2 Box 245 Imperial
---	--	---	---

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Interstitial Pneumonitis		
	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	19b. MAJOR FINDINGS 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 (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 7630
---	--	---

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 **8:25 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE Patrick E. Taylor	(Degree or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 5.7.54
--	-------------------	-----------------------------------	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 8th 1954	24c. NAME OF CEMETERY OR CREMATORY Mt Hope Cem.	24d. LOCATION (City, town, or county) (State) Lemay, Mo.
--	----------------------------------	---	--

DATE REC'D BY LOCAL REG. MAY 8 1954	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Fey Funeral Home	ADDRESS 4100 Lemay Ferry Rd
---	---	---	---------------------------------------

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.....
Signature of Student Embalmer

NOT EMBALMED

Signed..... *Wilton Dahlke*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.