

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26800**

FILED SEP 13 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 822-A

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Iowa</b> b. COUNTY <b>Polk</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield,</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Des Moines</b> <span style="float: right;">8140</span>	
c. LENGTH OF STAY (In this place) <b>10 hours</b>		d. STREET ADDRESS (If rural, give location) <b>1527 Des Moines</b> <span style="float: right;">8</span>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Springfield Baptist Hospital</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Charles</b> b. (Middle) <b>Elwood</b> c. (Last) <b>Byers</b>			4. DATE OF DEATH <b>August 29, 1954</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>December 25, 1920</b>
9. AGE (In years last birthday) <b>33</b> IF UNDER 1 YEAR Months <b>8</b> Days <b>3</b> IF UNDER 24 HRS. Hours Min.		11. BIRTHPLACE (City and State or Foreign Country) <b>Indianola, Iowa</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truckdriver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
11. CITIZEN OF WHAT COUNTRY? <b>USA</b>			

13a. FATHER'S NAME <b>Charles Byers</b>	13b. MOTHER'S MAIDEN NAME <b>Jessie Lees</b>	14. NAME OF HUSBAND OR WIFE <b>Maxine Byers</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>Yes. W. War II</b>	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Maxine Byers</b>	ADDRESS <b>Des Moines,</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		Ia. INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs</b>
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Severe intracranial damage</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Basilar skull fracture</b> DUE TO (c) <b>Trauma</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>			

19a. DATE OF OPERATION <b>8-29-54</b>	19b. MAJOR FINDINGS OF OPERATION <b>Emergency tracheotomy only</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Buffalo Dallas Mo</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Aug 29 1954 2:00 p.m.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Drove in ditch to avoid a truck.</b>
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22. I hereby certify that I attended the deceased from **Aug 28, 1954**, to **Aug 29, 1954**, that I last saw the deceased alive on **Aug 28** and that death occurred at **2:00 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Frank D. Sundstrom M.D.</b>	23b. ADDRESS <b>Springfield, Mo</b>	23c. DATE SIGNED <b>Aug 29, 1954</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Aug. 29, 1954</b>	24c. NAME OF CEMETERY OR CREMATOR <b>—</b>	24d. LOCATION (City, town, or county) (State) <b>Des Moines, Iowa</b>
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DATE REC'D BY LOCAL REG. <b>9-7-54</b>	REGISTRAR'S SIGNATURE <b>Francis Williamson</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Gorman-Scharpf Funeral Home, Inc.</b>	ADDRESS <b>Springfield, Missouri</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

MAR 14 1954

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 Lewis G. Scharpf

Licensed Embalmer No. 3802

P. O. Address Springfield, Ill.

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.