

STANDARD CERTIFICATE OF DEATH

FILED APR 18 1955

State File No. 3144
Registrar's No. 3144

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: 5701 Goodfellow Ave. | | e. STREET ADDRESS (If rural, give location) 5701 Goodfellow Ave. 20110 | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) Caroline b. (Middle) c. (Last) Byrne | | | 4. DATE OF DEATH (Month) (Day) (Year) Apr. 6, 1955 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Oct. 22 1883 | 9. AGE (In years last birthday) 71 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work | | 10b. KIND OF BUSINESS OR INDUSTRY home | | 11. BIRTHPLACE (City and State or Foreign Country) Illinois | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13a. FATHER'S NAME Ben Wittenbrink | | 13b. MOTHER'S MAIDEN NAME Louise Zoern | |
| 14. NAME OF HUSBAND OR WIFE Michel Byrne | | 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 Michel Byrne | | ADDRESS 5701 Goodfellow Blvd. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage | | II. OTHER SIGNIFICANT CONDITIONS | | 2 wks. | |
| * This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | 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. | | | |

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| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? 331x | |

22. I hereby certify that I attended the deceased from 1-13, 1954, to 4-6, 1955, that I last saw the deceased alive on 4-5, 1955, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) H. J. Hayden M.D. | | 23b. ADDRESS 730 Goodfellow Ave. | | 23c. DATE SIGNED 4/7/55 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 4/9/55 | | 24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens | |
| 24d. LOCATION (City, town, or county) (State) St. Louis, County Mo. | | 24e. DATE REC'D BY LOCAL REG. APR 8 1955 | | 24f. REGISTRAR'S SIGNATURE Charles Smith | |

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| 25. FUNERAL DIRECTOR'S SIGNATURE Buchholz Mortuary | | ADDRESS 5967 W. Florissant | |
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WRITE PLAINLY—USING UNFAADING 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

Signed *Walter B. Buckner*.....

Licensed Embalmer No. *755*.....

P. O. Address *St. Louis*.....

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.