

FILED APR 18 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **13171**
Registrar's No. **1338**

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. _____	
I. PLACE OF DEATH a. COUNTY Jackson b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City c. LENGTH OF STAY (in this place) 18 days d. FULL NAME OF HOSPITAL OR INSTITUTION Queen of The World Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Wyandotte c. CITY OR TOWN Kansas City d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐ e. STREET ADDRESS (If rural, give location) 4007 Thompson st.			
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) C. c. (Last) Byrd		4. DATE OF DEATH (Month) 3 (Day) 25 (Year) 1956					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower		8. DATE OF BIRTH 9-4-1893	
9. AGE 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscape Gardener		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (City and State or Foreign Country) Texarkana, Arkansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13a. FATHER'S NAME Robert Byrd		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Rhoda Byrd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Edwin Byrd		ADDRESS 2533 West Paseo K.C. Mo.	
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) Pulmonary Embolism ANTECEDENT CAUSES Due to (b) Interstitial Fibrosis Due to (c) Recent Transurethral Resection II. OTHER SIGNIFICANT CONDITIONS Benign Prostatic Hypertrophy Chronic Seminal Vesculitis				INTERVAL BETWEEN ONSET AND DEATH 610X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Benign Hyperplasia of Prostate				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) _____		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 March 10, 1956, to March 25, 1956, that I last saw the deceased alive on March 24, 1956, and that death occurred at 8:25 A.M., from the causes and on the date stated above.							
23a. SIGNATURE James F. O'Malley (Degree or title) M.D.				23b. ADDRESS 628 Professional Bldg.		23c. DATE SIGNED 3/27/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-29-1956		24c. NAME OF CEMETERY OR CREMATORY Westlawn Cemetery		24d. LOCATION (City, town, or county) (State) Kansas City, Kansas	
DATE REC'D BY LOCAL REG. 3-28-56		REGISTRAR'S SIGNATURE Neva Minshall		25. FUNERAL DIRECTOR'S SIGNATURE Mrs. J. W. Jones ADDRESS 440 State Ave.			

(Licensed Embalmer's Statement on Reverse Side)

K.C. Kansas

WRITE PLAINLY USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

^{affid}
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.....
Licensed Embalmer No. 416

P. O. Address H. C. O. St. Louis
K. C.

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.