

FILED MAY 25 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12655  
4494

|  |                        |  |   |   |   |   |   |   |  |
|--|------------------------|--|---|---|---|---|---|---|--|
| BIRTH NO. _____  |                        | REG. DIST. NO. 318   |   | PRIMARY REG. DIST. NO. 1003   |   | Registrar's No. _____   |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |                        |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri |   |   |   | b. COUNTY _____   |  |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis   |                        | c. LENGTH OF STAY (in this place) _____  |   | c. CITY OR TOWN St. Louis   |   | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute to City Hospital   |                        |  |   | e. STREET ADDRESS (If rural, give location) 22 1252 S. Broadway. 222/0                                      |   |   |   |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) MARGARET   |                        |  | b. (Middle) M.                          |   | c. (Last) BYRD  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br>5 6 56 |   |  |
| 5. SEX Female  | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed   | 8. DATE OF BIRTH 3-31-1880              |   | 9. AGE (In years last birthday) 76  | 10. IF UNDER 1 YEAR Months _____ Days _____   | 11. IF UNDER 24 HRS. Hours _____ Min. _____     |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife  |                        |  | 10b. KIND OF BUSINESS OR INDUSTRY _____ |   | 11. BIRTHPLACE (City and State or Foreign Country) Unknown                            |   | 12. CITIZEN OF WHAT COUNTRY? Unknown            |   |  |
| 13a. FATHER'S NAME Unknown   |                        |  | 13b. MOTHER'S MAIDEN NAME Unknown       |   |   | 14. NAME OF HUSBAND OR WIFE Deceased  |   |   |  |
| 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. _____           |   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br>Flora Hunt, 1106a Madison                |   |   |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.          |                        | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Malnutrition and General</i><br><br>ANTECEDENT CAUSES<br><i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i><br>DUE TO <i>Asteris Sclerosis</i><br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br><i>Conditions contributing to the death but not related to the disease or condition causing death.</i> |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH _____                                |  |
| 19a. DATE OF OPERATION _____   |                        | 19b. MAJOR FINDINGS OF OPERATION _____   |   |   |   |   |   | 20. AUTOPSY? YES <input 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 OF INJURY (Month) (Day) (Year) (Hour) _____  |                        | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21f. HOW DID INJURY OCCUR? _____  |   |   |   |   |  |
| 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 <i>226 P.</i> m., from the causes and on the date stated above. |                        |  |   |   |   |   |   |   |  |
| 23a. SIGNATURE <i>Patrick L. Taylor Carson</i> (Degree or title) _____   |                        |  |   | 23b. ADDRESS <i>1300 Clark</i>  |   |   |   | 23c. DATE SIGNED <i>5-9-56</i>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>   |                        | 24b. DATE <i>5-9-1956</i>  |   | 24c. NAME OF CEMETERY OR CREMATORY <i>St. Trinity Cem.</i>  |   | 24d. LOCATION (City, town, or county) (State) <i>St. Louis Co., Missouri</i>  |   |   |  |
| DATE REC'D BY LOCAL REG. <i>MAY 9 1956</i>   |                        | REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>   |   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>McLaughlin F.H., Inc., 2301 Lafayette</i> |   |   |   |  |

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

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(Licensed Embalmer's Statement on Reverse Side)

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..... *James R. Chapman*

Licensed Embalmer No. .... *4*

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.