

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023182
STATE FILE NUMBER

1003

6502

FILED JUL 14 1958 Registration District No. 318 Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY 3904 Ashland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis, Missouri
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3904 a Ashland		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 3904a Ashland
3. NAME OF DECEASED (Type or print) First Middle Last Jonnie Mae Byrd			4. DATE OF DEATH Month Day Year June 26, 1958
5. SEX Female	6. COLOR OR RACE Negro 3	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1910
9. AGE (In years last birthday) 48		IF UNDER 1 YEAR Months 4 Days 5	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 None	11. BIRTHPLACE (City and state or country) Mississippi / U.S.A.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Leroy Wiley	
13b. MOTHER'S MAIDEN NAME Annie Mae Bell		14. NAME OF HUSBAND OR WIFE Robert Byrd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Y no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Robert Byrd Address 2806 Gamble
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Apoplexy			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____			334x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from _____ and last saw her him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James M Kelly (Deputy Registrar)		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 6-28-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-1-'58	23c. NAME OF CEMETERY OR CREMATORY Greenwood	23d. LOCATION (City, town, or county) (State) St. Louis 20, Missouri
24. FUNERAL DIRECTOR G. B. Kaase	ADDRESS 1221 N. Grand	25. DATE REC'D BY LOCAL REG. JUN 28 1958	26. REGISTRAR'S SIGNATURE Earl Smith

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Lawrence Brown*

Licensed Embalmer No. *4755*
P. O. Address *12217th St*

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.