

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023183

STATE FILE NUMBER

FILED JUN 27 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6071

S. 300
1-57
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri 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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips			Length of stay in lb 3069		d. STREET ADDRESS (If outside, give location) 1322 Bayard		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pete Middle Last Byrd				4. DATE OF DEATH Month 6 Day 11 Year 58				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-5-1898		9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months 0 Days 6	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Issac Byrd			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Nettie Byrd		
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. 333-03-7721		17. INFORMANT Address Nettie Byrd 2818 Stoddard Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration + Melancholia DUE TO (b) Concussion of Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 153.8							INTERVAL BETWEEN ONSET AND DEATH undet.	
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 <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 5-13-58 to 6-11-58 and last saw ^{him} alive on 6-11-58 Death occurred at 2:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (In free or title) Carl Smith , M.D.				22b. ADDRESS 2601 Whittier Street		22c. DATE SIGNED 6-12-58		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-14-58	23c. NAME OF CEMETERY OR CREMATORY New Madrid		23d. LOCATION (City, town, or county) (State) Missouri			
24. FUNERAL DIRECTOR ADDRESS Ellis Funeral Home, Inc. 2820 Stoddard				25. DATE RECD. BY LOCAL REG. JUN 13 58	26. REGISTRAR'S SIGNATURE Carl Smith			

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 *Guilford E. Culkin*

Licensed Embalmer No. *4198*

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.