

Health,
Welfare
Public
Service

XC-UNKNOWN SL 18712

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002796

STATE FILE NUMBER

9
FILED JAN 26 1959

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

193

300
1-57
4
6 S

1. PLACE OF DEATH a. COUNTY St. Louis (CITY)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY 7	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N.GRAND, ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN BONNE TERRE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		Length of stay in lb 2 days	STREET ADDRESS (If outside, give location) 0944 STREET ADDRESS ROUTE 1 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ALFRED Middle L Last BYINGTON			4. DATE OF DEATH Month JANUARY Day 5 Year 1959		
---	--	--	--	--	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-21	9. AGE (In years last birthday) 37	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
-----------------------	----------------------------------	---	------------------------------------	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) ST. GENERIEVE, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	---	---	---

13a. FATHER'S NAME ELI BYINGTON	13b. MOTHER'S MAIDEN NAME STELLA PATERSON	14. NAME OF HUSBAND OR WIFE _____
---	---	--------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II	16. SOCIAL SECURITY NO. _____	17. INFORMANT VAH RECORDS Address 915 N.GRAND, ST. LOUIS, MO.
---	----------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EXTRADURAL HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH 36 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		_____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		_____

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NONE <input checked="" 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 _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) VA	20f. CITY, TOWN, OR LOCATION VA	COUNTY _____ STATE _____
---	--	---	---	--------------------------

21. attended the deceased from 1/3/59 to 1/5/59 and last saw him alive on 1/5/59 Death occurred at 1:20 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE J.P.S. Child (Degree or title) M.D.	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 1/5/59
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1 9 59	23c. NAME OF CEMETERY OR CREMATORY J. B. SHIELDS, N. D Three Rivers Cem.	23d. LOCATION (City, town, or county) (State) Rt 1 Bonne Terre, Mo.
--	----------------------------	--	---

24. FUNERAL DIRECTOR BOYER & SON FH Bonne Terre Mo	25. DATE RECD. BY LOCAL REG. JAN 8 '59	26. REGISTRAR'S SIGNATURE J Carl Smith, M.D.
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *B. T. Boyer*

B. T. BOYER

Licensed Embalmer No. 3660

P. O. Address Desloge, Mo.

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.