

# MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036679

FILED VS OCT 28 1959 60

Registration District No. \_\_\_\_\_ Primary Registration District No. 559v Registrar's No. 153

STATE FILE NUMBER

RECEIVED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>JEFFERSON Co</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FESTUS - Rural</u> Length of stay in lb _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MOUNTAIN VIEW Nur. Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST LOUIS</u> c. CITY OR TOWN <u>WEBSTER GROVES 19</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1231 ELM DRIVE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ANGELA</u> Middle <u>M</u> Last <u>BYRNE</u>			<b>4. DATE OF DEATH</b> Month <u>10</u> Day <u>17</u> Year <u>1959</u>					
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5-30-1875</u>	<b>9. AGE</b> (last birthday) <u>84</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HR</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and state or country) <u>SPRINGFIELD</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		
<b>13a. FATHER'S NAME</b> <u>THOMAS ARMSTRONG</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>MARY AUFFENBERGER</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>PATRICK J BYRNE</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> _____			<b>17. INFORMANT</b> Address <u>Mr Paul Naulon 1731 Elm Dr</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						INTERVAL BETWEEN ONSET AND DEATH <u>Worse 2 Wks</u>		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE		
<b>21. I attended the deceased from</b> <u>7-23-1959</u> to <u>10-17-1959</u> and last saw her alive on <u>10-17-1959</u> Death occurred at <u>3:00</u> P. m on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Degree or title) <u>R. D. D. [Signature] M.D.</u>				<b>22b. ADDRESS</b> <u>Crystal City, Mo.</u>		<b>22c. DATE SIGNED</b> <u>10-18-59</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>REMOVAL</u>		<b>23b. DATE</b> <u>10-20-59</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CALVARY CEMETERY</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>ST LOUIS MO</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>MITTELBERG WEBSTER GROVES MO</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>10/19/59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>John N. [Signature] Deputy</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS OCT 28 1959 SA

**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 Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. Louis 7

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.

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