

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-041642

FILED VS NOV 19 1959

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's **810117**

STATE FILE NUMBER

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		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes ☐ No ☐	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips			Inside Limits Yes ☒ No ☐		d. STREET ADDRESS (If outside, give location) 4064 Enright		Reside on Farm Yes ☐ No ☐
3. NAME OF DECEASED (Type or print) First Larry Middle Byrd Last Byrd				4. DATE OF DEATH Month 10 Day 31 Year 59			
5. SEX Male	6. COLOR OR RACE Negro	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH 3/17/02	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) Oklahoma		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Lula Ware			14. NAME OF HUSBAND OR WIFE Unknown	
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. none		17. INFORMANT Address Leroy Byrd 4130a Farlin		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intractable Heart Failure						INTERVAL BETWEEN ONSET AND DEATH Undet.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cor Pulmonale						Undet.	
DUE TO (c) 434.4							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Right Ventricular Hypertrophy						PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown	
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒	20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	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.	Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	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 8-29-59 to 10-31-59 and last saw him alive on 10-31-59		Death occurred at 9:05 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Edward B. Wiernicki				22b. ADDRESS 2601 Whittier St.		22c. DATE SIGNED 11-3-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/6/59	23c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, County, Mo			
24. FUNERAL DIRECTOR Grant Johnson		ADDRESS 4352 Wash. Blvd.		25. DATE RECD. BY LOCAL REG. NOV 4 1959		26. REGISTRAR'S SIGNATURE Reed Smith M.D.	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

F. Q. Green

Licensed Embalmer No. *2963*

P. O. Address *4214 Selma*

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.