

URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS DEC 16 1959

'59 0 4 4 7 1 4

STATE FILE NUMBER

Registration District No. 167

Primary Registration District No.

Registrar's No. 280

RECEIVED

1. PLACE OF DEATH a. COUNTY Livingston				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Livingston			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Blue Mound Twp.		Length of stay in 1b 1 yr.		c. CITY OR TOWN Dawn		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1 Mi E. of Dawn		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1 Mi. E. of Dawn		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last GRELTON A BYRD				4. DATE OF DEATH Month Day Year December 4, 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/10/81	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) Chillicothe, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Paul Byrd		13b. MOTHER'S MAIDEN NAME Catherine Gibbs		14. NAME OF HUSBAND OR WIFE Sadie Wier			
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. 90-42-0362		17. INFORMANT Mrs. Mary Gwinn; Dawn, Missouri			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
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)						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	
19. WAS AUTOPSY PERFORMED? YES <input 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 a.m. p.m. Month, Day, Year							
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 <u>Dec 4</u> to <u>Dec 4</u> and last saw him <u>Dec 4</u> Death occurred at <u>11:50</u> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Joseph A Conrad M.D. (Coroner)</u>				22b. ADDRESS <u>Chillicothe, Mo</u>		DATE SIGNED <u>Dec 7-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-7-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Christison Cemetery</u>		23d. LOCATION (City, town, or county) <u>Livingston County, Mo.</u>	
24. FUNERAL DIRECTOR		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Dec 7/59</u>		26. REGISTRAR'S SIGNATURE <u>Frances B Neill</u>	

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

NORMAN FUNERAL HOME: Chillicothe, Mo.

(Licensed Embalmer's Statement on Reverse Side)

DEC 28 1959

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

Edton F. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, M.

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.