

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 27 1960 245

=60-002639

Registration District No. _____ Primary Registration District No. 3047 Registrar's No. 11

STATE FILE NUMBER

| | | | | | | | |
|---|--|---|---|--|---|---|---|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY <u>Newton</u> | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Neosho</u> | | a. STATE <u>Mo.</u> | | b. COUNTY <u>Newton</u> | |
| | | Length of stay in lb <u>D.O.A.</u> | | c. CITY OR TOWN <u>Neosho</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sale Memorial Hospital</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>309 S. Lafayette</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| First <u>WILLIAM</u> | | Middle <u>F.</u> | | Last <u>BYRD</u> | | Month <u>January</u> Day <u>16</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-27-1894</u> | 9. AGE (last birthday) <u>65</u> | IF UNDER 1 YEAR | IF UNDER 24 HR |
| | | | | | | Months | Days |
| | | | | | | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Cook</u> | | 11. BIRTHPLACE (City and state or country) <u>Campton, Kentucky</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Willie Byrd</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Martha Williams</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Marie Byrd</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>Yes W.W. #1</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Mrs. Marie Byrd Neosho, Mo.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> | | | | | | | <u>Sudden</u> |
| DUE TO (b) <u>Hypertension - Arteriosclerosis</u> | | | | | | | <u>unknown</u> |
| 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 checked="" 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 | 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>did not attend</u> and last saw her/him alive on _____ | | | | | | | |
| Death occurred at <u>9:15 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Melvin C. Bowman M.D. Registrar</u> | | | | 22b. ADDRESS <u>Neosho, Missouri</u> | | | 22c. DATE SIGNED <u>1/19/60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>1-19-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Fayetteville, Arkansas</u> | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Clark Funeral Home Neosho, Mo.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>Jan. 19, 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Melvin C. Bowman M.D.</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 28 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Fred L. Clark

Licensed Embalmer No. 5086

P. O. Address 312 S. W. ...

Nebraska

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.