

UNITED STATES DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

60-010157

Registration District No. 50 Primary Registration District No. 5179 Registrar's No. 12

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Camden</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Camden</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Osage</u>		Length of stay in lb <u>13yrs</u>		c. CITY OR TOWN <u>Linn Creek</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Linn Creek</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R. Route 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Emmett</u> Last <u>Byars</u>				4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-6-1888</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>22</u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Mexico Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Robert Todd Byars</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Ida M. Byars</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>333-01-4195A</u>		17. INFORMANT Address <u>Mrs Ida Byars, Linn Creek, Mo.</u>			
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>Pulmonary Emphysema</u> DUE TO (b) <u>Sclerosis</u> DUE TO (c) <u>Cardio Vascular Renal Disease</u> 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) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>10 years</u> <u>3 years</u>	
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.) <u></u>				20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>			
20d. INJURY OCCURRED WHILE AT WORK <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.) <u></u>		20f. CITY, TOWN, OR LOCATION <u></u>		COUNTY <u></u> STATE <u></u>	
21. I attended the deceased from <u>April 1959</u> to <u>Mar-28-60</u> and last saw him alive on <u>Mar-28-60</u> Death occurred at <u>11 a.m. Mar-28-60</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) <u>Thomas A. Wayland M.D.</u>				22b. ADDRESS <u>Camdenton, Mo</u>		22c. DATE SIGNED <u>Mar-30 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Mar. 31, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Blair Memorial Cemetery</u>		23d. LOCATION (City, town, or county) <u>Camdenton, Mo.</u>	
24. FUNERAL DIRECTOR <u>Reed Funeral Home, Camdenton Mo.</u>		ADDRESS <u></u>		25. DATE RECD. BY LOCAL REG. <u>Mar 31-1960</u>		26. REGISTRAR'S SIGNATURE <u>Zilpha L. Traw</u>	

ENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 4 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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address Camden 7

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.