

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 23 1960

-60-019149

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 147

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Henry Co</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Henry</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton Mo</u>		Length of stay in 1b		c. CITY OR TOWN <u>Clinton Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>718 W Rodgers Clinton</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>718 W. Rodgers</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Webster</u> Middle <u>Clay</u> Last <u>Byler</u>				4. DATE OF DEATH Month <u>May</u> Day <u>15<sup>th</sup></u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wht</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1876</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sell</u>		11. BIRTHPLACE (City and state of country) <u>Peoria Co Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>James H. Byler</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Mc Donald</u>			14. NAME OF HUSBAND OR WIFE <u>Widower</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>1</u>		17. INFORMANT <u>Mrs. R. W. Hall</u> Address <u>Wendover</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>Insanition -</u> DUE TO (b) <u>Intestinal Obstruction - Ca of stomach 5 mos.</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks -</u>	
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 <u>6:15 am</u> Month, Day, Year <u>July 1959</u>								
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>July 1959</u> to <u>5-15-60</u> and last saw him alive on <u>5-15-60</u> Death occurred at <u>6:15 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>W. D. Bradshaw, M.D.</u> (Degree or title)				22b. ADDRESS <u>Clinton, Mo.</u>		22c. DATE SIGNED <u>5-15-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-17-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sedalia Comm Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Sedalia Mo Pettis Co</u>		
24. FUNERAL DIRECTOR <u>Erving F. Howe</u>		ADDRESS <u>Sedalia Mo</u>		25. DATE RECD. BY LOCAL REG. <u>May 17 1960</u>		26. REGISTRAR'S SIGNATURE <u>Hildred Bigum</u>		

(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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*R. E. Baker*

Licensed Embalmer No. *2419*

P. O. Address *Sedalia*

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