

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-019886

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 60

1. **FILED MAY 18 1962**

a. COUNTY Pulaski

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN Waynesville

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION Pulaski Co. General Hosp.

Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Phelps

c. CITY OR TOWN Rural Livery Twn.

Inside Limits
Yes ☐ No ☒

d. STREET ADDRESS (If outside, give location)
Rt. #2, Newburg, Missouri

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Maudie

Leona

Byers

4. DATE OF DEATH

Month

Day

Year

5

4

1962

5. SEX
Female

6. COLOR OR RACE
White

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH
1/7/1885

9. AGE (last birthday)
77

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)
Housework

10b. KIND OF BUSINESS OR INDUSTRY
Own Home

11. BIRTHPLACE (City and state or country)
Wappapello, Missouri

12. CITIZEN OF WHAT COUNTRY
U. S. A.

13a. FATHER'S NAME

Unknown

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

John Byers

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
Mrs. Verle West, Hooker, 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)

Senile Degeneration

INTERVAL BETWEEN
ONSET AND DEATH

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Lobar Pneumonia

DUE TO (c)

Cholecystitis

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.

☐ 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 past 6 yrs. to 7:55 and last saw her alive on 5-16-62
Death occurred at 7:55 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal

23b. DATE

5/4/1962

23c. NAME OF CEMETERY OR CREMATORY

Augusta Cemetery

23d. LOCATION (City, town, or county)

Augusta, Arkansas

24. FUNERAL DIRECTOR

ADDRESS

Gilbert Funeral Home, Inc., Dixon, Mo.

25. DATE RECD. BY LOCAL REG.

5-16-62

26. REGISTRAR'S SIGNATURE

Paula Lynn Anderson

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 Maurice E. Schierbaum

Licensed Embalmer No. 4505

P. O. Address Dixon, Missouri

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.