

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

36 -63-002841

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 275

Primary Registration District No. 3053

Registrar's No.

FILED FEB 13 1963

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u>		c. CITY OR TOWN <u>Lillburn</u>	
Length of stay in lb <u>2 Weeks</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>McFarland Nurseing Home</u>		d. STREET ADDRESS (If outside, give location) <u>none</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PERRY</u> Middle <u>ALLEN</u> Last <u>BYRD</u>		4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/1940</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>No Occupation, Invalid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
13a. FATHER'S NAME <u>Perry T. Byrd</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>None</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> <u>none</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Perry T. Byrd Lillburn, 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>Pneumonia</u> DUE TO (b) <u>Influenza</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral palsy -</u>		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>-</u> a.m. <u>-</u> p.m. Month, Day, Year <u>-</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 <u>Rolla, Mo.</u>	
20g. COUNTY <u>Dexter, Mo.</u>		20h. STATE <u>Mo.</u>	
21. I attended the deceased from <u>6. P.</u> to <u>-</u> and last saw her/him alive on <u>-</u> Death occurred at <u>-</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. Andreasen MD</u>		22b. ADDRESS <u>Rolla, Mo.</u>	
22c. DATE SIGNED <u>2/11/63</u>		22d. LOCATION (City, town, or county) (State) <u>Dexter, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2/10/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>	
24. FUNERAL DIRECTOR <u>Watkins Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 10, 1963</u>	
ADDRESS <u>Dexter, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Nadene L. Stoll</u>	

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

VS 300  
Rev. 4/59

10817

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131-0

**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 \_\_\_\_\_

*Carl J. Glenn*

Licensed Embalmer No. 4707

P. O. Address Rolla, Mo.

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.