

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=63-021407**

**318**

**1003**

**5048**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. Primary Registration District No. Registrar's No.

**FILED MAY 17 1963**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>12 Hrs</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Incarnate Word Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>6761 Hoffman Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HULDA</b> Middle <b>I.</b> Last <b>BYRD</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-24-1905</b>
9. AGE (last birthday) <b>57</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector-Packer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metal Mfg.</b>	
11. BIRTHPLACE (City and state or country) <b>Norfolk, Nebr.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Paul Brummund</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Benning</b>	
14. NAME OF HUSBAND OR WIFE <b>Everett L. Byrd</b>		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>487-20-1124</b>	
17. INFORMANT <b>Everett L. Byrd,</b>		Address <b>above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> Essential Hypertension Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>331X</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs.</b> <b>Unknown</b>
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 checked="" 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 a.m. p.m. 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 <b>March 1955</b> to <b>May 7, 1963</b> and last saw her alive on <b>May 7, 1963</b> Death occurred at <b>11:10 a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Paul Schmitt</i> (Degree or title) <b>MD</b>	22b. ADDRESS <b>2730 Watson Rd. St. Louis 39, Mo.</b>		22c. DATE SIGNED <b>5-8-63</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-10-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR <b>JAY B. SMITH, Maplewood, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 10 1963</b>	
26. REGISTRAR'S SIGNATURE <i>Paul Smith. M.D.</i>			

USE BLACK INK

OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300  
Rev. 4/59

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S. Schults MD

MI 7-5150

**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 W. B. Burgess

Licensed Embalmer No. 4027

P. O. Address Maplewood

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.