

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 28 1944

Registration District No. Primary Registration District No. 6073 Registrar's No. 151

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County St. Louis

(b) City or town Bonnie-Linn, Mo. P. 110 No. 1
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: RURAL PERRY TWP.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether)

In this community..... (Specify whether)

years, months or days

3. (a) PRINT FULL NAME Mr. James Byington

3. (b) If veteran, name war..... (c) Social Security No.....

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Cor. William Byington 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased June 22 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

78 8 10 hr. min.

9. Birthplace St. Genevieve Co. MO
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Mr. James Byington

13. Birthplace Potomac, Md. MO
(City, town, or county) (State or foreign country)

14. Maiden name Detorah Seal

15. Birthplace Potomac, Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Luella Sign & Mrs. Wm. Cepink

(b) Address Northwood, Bonnie-Linn, Mo.

17. (a) Burial (b) Date thereof March 4 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary St. Genevieve, Mo.

18. (a) Signature of funeral director Albert W. Hood

(b) Address 363 Crum St. St. Louis, Mo.

19. (a) March 4-1944 (b) Byndis Burkmaster
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ohio (b) County 999

(c) City or town Cleveland 33
(If outside city or town limits, write "RURAL") 0

(d) Street No..... (If rural, give location)

(e) Citizen of foreign country?..... (Yes or No) 2
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1
year 1944 hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from Dec 26
1943 to Mar 1 1944

that I last saw him alive on Mar 1 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Stenosis

Due to Infermiatic Anger

Due to

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings: QFA

Of operations.....

Of autopsy.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature W. M. ... (M. D. or other) 20

Address Bonnie-Linn Mo. Date signed 3/4-44

RECEIVED

District Health Officer No. 4

District File Number 344-3600

Date Filed 3-27-44

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Alvin W. Hood

Licensed Embalmer No. 2780

P. O. Address Flat Room W. 303 Crane St

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 this body is not embalmed, fact should be so stated above.