No. 2
12-45
17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 38453

FILED NOV 25 1946

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9728

**1. PLACE OF DEATH:**

(a) County

(b) City or town ST. LOUIS.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: MO. BAPTIST HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
(Specify whether)
In this community
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO. (b) County OLO

(c) City or town ST. LOUIS. 237
(If outside city or town limits, write "RURAL")

(d) Street No. 2614 PARK AV. 9
(If rural, give location) 0

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME JAMES BYINGTON.

3. (b) If veteran, name war WORLD WAR I

3. (c) Social Security No. 497-10-5440

4. Sex MALE

5. Color or race W.

6. (a) ~~Single~~, widowed, married, divorced MARRIED

6. (b) Name of husband or wife FRANCES C. BYINGTON

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased OCTOBER (Month) 20 (Day) 1901 (Year)

8. AGE: Years 45 | Months 0 | Days 22 | If less than one day hr. min.

9. Birthplace FLAT RIVER (City, town, or county) MO. (State or foreign country)

10. Usual occupation

11. Industry or business Chauffeur.

MOTHER / FATHER

12. Name JOSEPH H BYINGTON

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

14. Maiden name EFFIE MARTIN

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

16. (a) Informant MRS FRANCES C. BYINGTON

(b) Address 2614 PARK AV

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 15-46 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ MEMORIAL PARK CEM

18. (a) Signature of funeral director E. J. SCHMUL.

(b) Address 3125 LAFAYETTE AV.

19. (a) NOV 15 1946 (Date received local registrar) J. F. BREDECK (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month NOV day 12
year 1946 hour 10 minute 15 P.M.

21. I hereby certify that I attended the deceased from 5-14-46 to 11-12-46
that I last saw him alive on NOV 12 1946
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to Lung abscess Non-tubercular | 6 MO. |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations Confirmed above.
Of autopsy

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature James L Arnold (M. D. or other)

Address 634 N GRAND Date signed 6/14/46

(Licensed Embalmer's Statement on Reverse Side)

## 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. Jos B Wolcott

Licensed Embalmer No. 4614

P. O. Address Bar Harbor Me

**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.**