

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

- (a) County St. Francois
- (b) City or town Flat River, Mo.
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

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

In this community _____

3. (a) PRINT FULL NAME

Mr. Newton A. Byington

3. (b) If veteran, name war _____

3. (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 Frances Mary Byington
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 11 1865
(Month) (Day) (Year)

8. AGE: Years 73 Months 10 Days 3 If less than one day
hr. _____ min.

9. Birthplace St. Genevieve County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Mr. William Byington
13. Birthplace St. Genevieve Co. Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Anna Lassusier
15. Birthplace St. Genevieve Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mr. Tom Byington

(b) Address Flat River, Mo.

17. (a) Burial (b) Date thereof Sept 16 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richardson C. Byington

18. (a) Signature of funeral director Alvin W. Hoff

(b) Address Flat River, Mo.

19. (a) 9-16-39 (b) G. B. Farrar M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County St. Francois
- (c) City or town Flat River
(If outside city or town limits, write "RURAL")
- (d) Street No. _____ (If rural, give location)
- (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 15
year 19-39 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Aug 28
_____, 1939, to Sept 14, 1939;
that I last saw him alive on Sept 8, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death RT foot gangrene Duration _____

Caused by -
Due to arterio sclerosis

Due to _____

Other conditions 97
(Include pregnancy within 3 months of death)

Major findings: Of operations

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature C. H. Byington (M. D. or other) MD
Address Flat River MO Date signed 9-18-39

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 River, 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 this body is not embalmed, above space should be left blank.