

FILED JAN 26 1959

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

193

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1-57  
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1. PLACE OF DEATH a. COUNTY <b>St. Louis (CITY)</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>7</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>915 N. GRAND, ST. LOUIS, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>BONNE TERRE</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADM. HOSPITAL</b>		Length of stay in lb <b>2 days</b>	STREET ADDRESS (If outside, give location) <b>0944 STREET ADDRESS ROUTE 1</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ALFRED</b> Middle <b>L</b> Last <b>BYINGTON</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>5</b> Year <b>1959</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-14-21</b>	9. AGE (In years last birthday) <b>37</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	11. BIRTHPLACE (City and state or county) <b>ST. GENERIEVE, MO.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>ELI BYINGTON</b>	13b. MOTHER'S MAIDEN NAME <b>STELLA PATERSON</b>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES</b> <b>WW-II</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <b>VAH RECORDS 915 N. GRAND, ST. LOUIS, MO.</b> Address
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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>EXTRADURAL HEMORRHAGE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 HOURS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____		_____
DUE TO (c) _____		_____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		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"/> NONE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____
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20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____
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21. attended the deceased from <b>1/3/59</b> to <b>1/5/59</b> and last saw <del>him</del> <sup>her</sup> alive on <b>1/5/59</b> Death occurred at <b>1:20 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>J.P.S. Child</i>	(Degree or title) <b>M.D.</b>	22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>1/5/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1 9 59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>J. B. SHIELDS, N. D Three Rivers Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Rt 1 Bonne Terre, Mo.</b>
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24. FUNERAL DIRECTOR <b>BOYER &amp; SON FH Bonne Terre Mo</b>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <b>JAN 8 '59</b>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> <b>M. J. B.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *B. T. Boyer* .....  
B. T. BOYER  
Licensed Embalmer No. 3660  
P. O. Address Desloge, 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.