

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30373

STATE FILE NUMBER

FILED SEP 9 1957

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2086

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis Co.</u>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>          |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                               | c. CITY OR TOWN <u>Farmington, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                 |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>132 W. E. I. M.</u> Length of stay in 1b <u>2 YEARS</u>   |                               | d. STREET ADDRESS (If outside, give location) _____ Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>                           |  |
| 3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Ann</u> Last <u>Byrington</u>  |                               |  | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>18</u> Year <u>1957</u>          |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 20, 1859</u>                                      |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>   |                               | 9b. KIND OF BUSINESS OR INDUSTRY _____   | 9. AGE (In years last birthday) <u>98</u>                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY _____  | 11. BIRTHPLACE (City and state or country) <u>Near Farmington, Mo.</u>     |
| 13. FATHER'S NAME <u>Thomas Harvey Haile</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Campbell</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____  |                               | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u>   | 17. INFORMANT <u>Mrs. C. J. Davis Webster Groves, Mo.</u>                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u><br>DUE TO (b) <u>Arteriosclerotic-vascular</u><br>DUE TO (c) <u>disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |                               |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 da</u><br><u>chr.</u>                |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |                               | 200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>1491X</u>  |  |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>  |  |
| 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 <u>Aug 18 1955</u> to <u>Aug 18 1957</u> and last saw her <u>him</u> alive on <u>Aug 18 1957</u> . Death occurred at <u>6:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.   |                               |  |  |
| 22a. SIGNATURE (Degree or title) <u>Ed Debaugh M.D.</u>  |                               | 22b. ADDRESS <u>Webster Groves Mo 8/19/57</u>  | 22c. DATE SIGNED _____   |
| 23a. BURIAL CREMATION <u>REMOVAL</u>   | 23b. DATE <u>Aug. 20-57</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Masonic</u>  | 23d. LOCATION (City, town, or county) <u>Farmington, Mo.</u> (State) _____ |
| 24. FUNERAL DIRECTOR <u>C. H. Cozean</u> ADDRESS <u>Farmington, Mo.</u>  |                               | 25. DATE RECD. BY LOCAL REG. <u>8-21-57</u>  | 26. REGISTRAR'S SIGNATURE <u>Herbert B. Donald</u>                         |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner cannot certify to a death due to natural causes. Must be causally related. Diseases in Part 1 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.....  
*A. Cozart*

Licensed Embalmer No.....

P. O. Address.....  
*Ferris*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.