

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DESD MAR 13 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

5009
Do not use this space.

1. PLACE OF DEATH
 (a) County St. Louis, Mo. Registration District No. 791
 (b) Township _____ Primary Registration District No. 1003
 (c) City St. Louis, Mo. (d) Street No. Bethesda Hospital - 3649 Unkane St. Registered No. 1702
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. 3 mos. 29 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME H. W. CHARLES W. TYLER.
 (a) Residence, No. HULLVILLE, MO. St. NR
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED-OR DIVORCED (write the word) SINGLE

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 1, 1923

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
15 1 4 29

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Student.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation.

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DALLAS, TEXAS
 13. NAME J. W. TYLER JR.
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) HULLVILLE, MO.

MOTHER
 15. MAIDEN NAME BERTHA OWEN
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DALLAS, TEXAS

17. INFORMANT FATHER - J. W. TYLER JR.
 (ADDRESS) Hullville Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Higginsville, Mo. DATE 2/24 1939

19. FUNERAL DIRECTOR Albert H. Hopp
 (ADDRESS) 4700 Washington

20. FILED FEB 23 1939
J. B. Brubaker
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-22 1939

22. I HEREBY CERTIFY That I attended deceased from Oct. 23 1938 to Feb. 22 1939
 I last saw him alive on Feb. 22 1939 Death is said to have occurred on the date stated above, at 5:15A.
 The principal cause of death and related causes of importance were as follows:
Old Pott's disease of spine
congenital abscess of rt. lung
hypostatic pneumonia
broncho
 Other contributory causes of importance:
none
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? 1
 If so, specify _____
 (Signed) J. S. Copenscheck M. D.
 (Address) 3649 Unkane

1702

1702

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed *Albert G. Hoff*

Licensed Embalmer No. *2971*

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.)