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.

REC'D MAR 13 1939

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

6601
Do not use this space.

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1. PLACE OF DEATH
(a) County Greene Registration District No. 318
(b) Township ... Primary Registration District No. 5439 Registered No.
or
(c) City Springfield (d) Street No. Springfield Air Port R #2 St.
(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. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Wm Tyrlick
(a) Residence, No. Wheatland, N.D. St. Wheatland N. D.
(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 17 1918

7. AGE ✓ YEARS 20 MONTHS 3 DAYS 20 If LESS than 1 day, ...hrs. or ....min.

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. Farming.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wheatland N.D.

FATHER
13. NAME David Tyrlick
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria

MOTHER
15. MAIDEN NAME Tekla Bobak
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria

17. INFORMANT (ADDRESS) Joseph Tyrlick Springfield Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Casselton N.D. DATE Feb 7 1939

19. FUNERAL DIRECTOR (NAME) H. H. Whitney Jr. (ADDRESS) Springfield Mo

20. FILED Feb 7 1939 Chas A. George M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) FEB. 7. 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw him DEAD alive on FEB. 7, 1939. Death is said to have occurred on the date stated above, at 8 A. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Sarcoma of Lungs.	

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Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

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? .....
If so, specify .....
(Signed) J. P. Ferguson Coroner, M.D.
(Address) Greene Co

(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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

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