

FILED SEP 24 1940

STANDARD CERTIFICATE OF DEATH

State File No. 29126

Registration District No. 567

Primary Registration District No. 6763

Registrar's No. 671

1. PLACE OF DEATH:  
 (a) County Mississippi  
 (b) City or town Anniston  
 (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) 2  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community 4 mo (Specify whether years, months or days) 1/60

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Mississippi  
 (c) City or town Anniston, Mo.  
 (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.

3. (a) PRINT FULL NAME CAROL EUGENE TYLER

3. (b) If veteran, name war L 3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 1, 1940  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
4 11 \_\_\_\_\_ hr. min.

9. Birthplace Mississippi Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Bunk Tyler

13. Birthplace Randolph Co. Arkansas  
 (City, town, or county) (State or foreign country)

14. Maiden name Grace Hooker

15. Birthplace Charleston Mo.  
 (City, town, or county) (State or foreign country)

16. (a) Informant Bunk Tyler

(b) Address Anniston Mo.

17. (a) Burial (b) Date thereof Aug. 13, 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove

18. (a) Signature of general director Frank Shelby

(b) Address East Prairie Mo.

19. (a) Sept 3, 1940 (b) Mrs M. Hodge  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12  
 year 1940 hour 12 minute P M.

21. I hereby certify that I attended the deceased from Aug 10  
 1940 to Aug 16 1940;  
 that I last saw him alive on Aug 12 1940;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition Duration 2 mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?  
 \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Paul S. Saw (M. D. or other) \_\_\_\_\_

Address Charleston Mo. Date signed \_\_\_\_\_

Duration  
 2 mo  
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer M

District File Number 940-1

Date Filed 9/13/4

858/1

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

working under my personal supervision.

Registered Apprentice No.

Signed

*Travis Shelby*

Licensed Embalmer No. 2726

P. O. Address East Prairie

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

If this body is not embalmed, fact should be so stated above.

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **29126**

Registration District No. **367**

Primary Registration District No. **5763**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Mississippi**  
(b) City or town **St. James, T.P.**  
(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 \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME **Carol Eugene Tyler**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**4 11** hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 **Aug** day **12**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.  
Immediate cause of death **malnutrition** Duration \_\_\_\_\_

Due to **neglect**  
**of proper + insufficient food**

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) **158**

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 **Paul B. Bam** (M. D. or other) **MD**  
Address **Charleston, Mo.** Date signed **10/22**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

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