

District No. **89**

Primary Registration District No. **3007**

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Poplar Bluff Hospital
(If not in hospital or institution, write street/number or location)
(d) Length of stay: In hospital or institution 8 DAYS
In this community About 8 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME EE TYLER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race white 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife LULA TYLER 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Jan 7 1877
(Month) (Day) (Year)

8. AGE: Years 62 Months 5 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation Salesman

11. Industry or business Wholesale Grocery

12. Name Wash Tyler

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

14. Maiden name unknown

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

16. (a) Informant Mrs Lula Tyler

(b) Address Poplar Bluff Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-6-41
(Month) (Day) (Year)

(c) Place: burial or cremation Missouri Cemetery

18. (a) Signature of funeral director H. M. Nabb

(b) Address Peabodys Ark

19. (a) 7/14/41 (Date received local registrar) (b) Edw. Kate Lutz (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler
(c) City or town Poplar Bluff
(If outside city or town limits, write "RURAL")
(d) Street No. 914 Nooney Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6th
year 1941 hour 10 minute 15 A M.

21. I hereby certify that I attended the deceased from June 27
1941 to July 6, 1941

that I last saw him alive on July 16, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 10 days

Due to Hypertension

Due to _____

Other conditions gzw
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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) none

(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 _____

28. Signature C. H. Porter (M. D. or other) D
Address Poplar Bluff, Mo Date signed 7-14-41

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

MOTHER FATHER

JUL 29 1941

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 H. G. Mc Nabb
Licensed Embalmer No. 477
P. O. Address Focaheuta, Ark

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

Registration District No. 89

Primary Registration District No. 3007

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

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Butler Bluff
(c) Name of hospital or institution Cape Girardeau Hospital
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(d) Street No. _____
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME ERASTUS EZRA TYLER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 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 _____ 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) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-23-41 (b) Belle Kinnel
(Date received local registrar) (Registrar's signature)

19. MEDICAL CERTIFICATION

20. DATE OF DEATH _____ Month _____ day _____
year _____ 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 _____
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? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

