

FILED FEB 5 1943

State File No. ....

Registration District No. 85 42

Primary Registration District No. 1001/1000

Registrar's No. 135

1. PLACE OF DEATH:

(a) County BUCHANAN  
(b) City or town ST. JOSEPH  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital # 2 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City // (If outside city or town limits, write "RURAL")  
(d) Street No. 4609 Wabash / (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 24<sup>th</sup> day January  
year 1943 hour 7:57 minute A. M.

21. I hereby certify that I attended the deceased from Jan 1, 1943 to Jan 24, 1943  
that I last saw her alive on Jan 24, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia Duration  
Chronic Myocarditis

Due to Influenza

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

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

Major findings: 930  
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 R.B. Sweeney M.D. or other M.D.  
Address State Hospital, St. Joseph, Mo. Date signed Jan 24 1943

3. (a) PRINT FULL NAME Mayloee Tyrrell  
3. (b) If veteran, name war \_\_\_\_\_ No. \_\_\_\_\_  
3. (c) Social Security \_\_\_\_\_

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

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

7. Birth date of deceased Nov. 2, 1894  
(Month) (Day) (Year)

8. AGE: (Years) (Months) (Days) (48 8 29) If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation None

11. Industry or business None

12. Name Nathan Tyrrell

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

14. Maiden name Katherine Bowen

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

16. (a) Informant Mrs. Ruby E. Asten

(b) Address 8130 Troost, Kansas City, Mo.

17. (a) Removal (b) Date thereof Jan 24, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt. Moriah Cem. Kansas City

18. (a) Signature of funeral director Clark Mortuary

(b) Address 5025 King Hill Ave.

19. (a) 1-24-43 (b) Rae Feigog  
(Date received local registrar) (Registrar's signature)

1233 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

---

---

**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 *Emmanuel Clark*.....

Licensed Embalmer No. *4238*.....

P. O. Address *St Joseph*.....

**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, fact should be so stated above.**