

FILED APR 20 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13444

Registration District No. 318

Primary Registration District No. 1002

Registrar's No. 3393

1. PLACE OF DEATH:

(a) County.....
(b) City or town. St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
31 02 Clark Ave.
(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:

Ho. 600
(a) State..... (b) County.....
(c) City or town. St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3102 Clark Ave.
(If rural, give location)
(e) Citizen of foreign country?..... No.
(Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Josie Tyler

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

4. Sex F 5. Color or race Col. 6. (a) Single, widowed, married, divorced 9
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years abt 57 Months Days If less than one day
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name David Tyler
13. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Louie
15. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Anna Mae Henry

(b) Address 797 So. Harrison Ave.

17. (a) Burial (b) Date thereof 4 13 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director A. L. Beal Uad. Co.

(b) Address 2726 Lucas Avenue

19. (a) APP 12 1944 J. F. Brudick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10th
year 1944 hour 9 minute a M.

21. I hereby certify that I attended the deceased from April 1
....., 1944, to April 8, 1944
that I last saw h..... alive on April 8, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death = Congestive Heart Failure Duration
95

Due to Hypertension

Due to 95

Other conditions (Include pregnancy within 3 months of death)

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?
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature W. A. Young (M. D. or other)
Address 2316 Maple St. Date signed.....

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

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

Richardson
Licensed Embalmer No. *8952*
P. O. Address.....
City

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 3393

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town St Louis
(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)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Jessie Tyler
3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced, Widowed

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 57 Months Days no (Less than one day) min.

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

10. Usual occupation Unemployed

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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) MAY 2 1944 (b) J. F. Budack (Date received local registrar's certificate) (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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 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)

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
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..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

13444