

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10992**

FILED APR 18 1955

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 89

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Columbia</u>	c. LENGTH OF STAY (in this place) <u>1 yr.</u>	c. CITY OR TOWN <u>Columbia</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>		STREET ADDRESS (If rural, give location) <u>600 South Williams</u> <u>0105</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ARTHUR</u>	b. (Middle) <u>WILLIAM</u>	c. (Last) <u>TYLER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 9, 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 28, 1878</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinest</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>New York</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Tyler</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah (unknown)</u>	14. NAME OF HUSBAND OR WIFE <u>Carrie Longist</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Arthur Tyler, Columbia, Mo.</u>	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 15 min.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of rectum</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Cerebral & renal arteriosclerosis</u>	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>154X</u>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 6-3, 1954, to 4-9, 1955, that I last saw the deceased alive on 4-9, 1955 and that death occurred at 11:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>RP Anderson MD</u> (Degree or title)	23b. ADDRESS <u>Columbia, Mo</u>	23c. DATE SIGNED <u>4-12-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>April 12, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri.</u>
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DATE REC'D BY LOCAL REG. <u>April 12, 1955</u>	REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u> <u>31</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Parsons Funeral Service, Columbia Mo</u>	ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

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

EX-15 1955

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *M. S. Philetich*

Licensed Embalmer No. *38*

P. O. Address *Columb*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.