

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 8 - 1955

State File No. **31920**
Registrar's No. **2152**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500**

1. PLACE OF DEATH a. COUNTY St. Louis,		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Melrose Park		c. CITY OR TOWN St. Louis,	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 2 wks		e. STREET ADDRESS #5418 Bartmer Ave,	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Melrose Road. (Rural Rt.)			

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) ELIZABETH c. (Last) TYHURST.			4. DATE OF DEATH (Month) (Day) (Year) Sep't 13, 1955.		
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5. SEX Female.	6. COLOR OR RACE White.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single.	8. DATE OF BIRTH April 3, 1876.		9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired..		10b. KIND OF BUSINESS OR INDUSTRY Domestic.	11. BIRTHPLACE (City and State or Foreign Country) Johnson Township, Illinois.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John A. Tyhurst.		13b. MOTHER'S MAIDEN NAME Sarah Bayles.		14. NAME OF HUSBAND OR WIFE None.	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no. (If yes, give war or date of service) no.		16. SOCIAL SECURITY NO. none.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ernest Lewitz, #611 Olive Street,		
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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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malnutrition			INTERVAL BETWEEN ONSET AND DEATH 1 mo
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pernicious anemia			2 years
		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 2900		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) m.		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 **Sept 9, 1955**, to **Sept. 13, 1955** that I last saw the deceased alive on **9-5**, 19**55**, and that death occurred at **8 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE Louis C. Dwyer (Degree or title) M.D.		23b. ADDRESS 134 St. Adams		23c. DATE SIGNED 9-15-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation.		24b. DATE 9/15/55.	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory.		24d. LOCATION (City, town, or county) (State) #7800 St. Charles Rock Road.	
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DATE REC'D BY LOCAL REG. 9-15-55		REGISTRAR'S SIGNATURE Herbert R. Dombrowski		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. Lupton & Sons, #7233 Delmar Blv'd.,	
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S.G. (Licensed Embalmer's Statement on Reverse Side)

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

A 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 *Arnold W. Schoene*.....

Licensed Embalmer No. *386*.....

P. O. Address *St Louis*.....

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.