. Health,
& Welfare
S. Public
h Service

S. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAY - 8 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15395
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3941

1. PLACE OF DEATH a. COUNTY ~~ST. Louis Missouri~~	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 01 4332 St. Louis Ave. — Length of stay in 1b 2	d. STREET ADDRESS (If outside, give location) 11 4332 St. Louis — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Katie Middle Last Tyler	4. DATE OF DEATH Month April Day 23 Year 1957		
5. SEX 2 Female	6. COLOR OR RACE Col	7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH 9 Feb 1884
9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 2 Days 14	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Tunia Mississippi	12. CITIZEN OF WHAT COUNTRY? U. S.A.
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT Julia Gibbs Address 4332 St. Louis	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) 444X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Jan. 1954, to April 23d and last saw her/him alive on April 22nd 57. Death occurred at 6 A.M. 4332 Stevens Ave in on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. H. Wilkerson MD	22b. ADDRESS 4141 Page Stevens	22c. DATE SIGNED 4-24-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/26/57	23c. NAME OF CEMETERY OR CREMATORY Washington Park
23d. LOCATION (City, town, or county) (State) St. Louis County Mo		
24. FUNERAL DIRECTOR Herman J. Smith ADDRESS 4247/w Labadie	25. DATE RECD. BY LOCAL REG. APR 25 '57	26. REGISTRAR'S SIGNATURE J Earl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed W. Clyde Gardner

Licensed Embalmer No. 348

P. O. Address 475 Al

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.