

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023483

STATE FILE NUMBER 6206

FILED JUL 13 1959

Registration District No. Primary Registration District No.

Registrar's No.

S. 300  
v. 1-57

8  
69.7

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>1709 Marcus</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Homer</b> Middle Last <b>Tyler</b>			4. DATE OF DEATH Month <b>6</b> Day <b>29</b> Year <b>59</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-6-1892</b>
9. AGE (In years (by birthday) Months Days)		9. AGE (In years (by birthday) Months Days) <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nil.</b>	11. BIRTHPLACE (City and state or country) <b>Jonesburg Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Morris Tyler</b>	
13b. MOTHER'S MAIDEN NAME <b>Massoui Getter</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes W.W. 2</b>		16. SOCIAL SECURITY NO. <b>493-10-7010</b>	17. INFORMANT <b>Ardean Patterson 219 Bowen</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Larynx with Metastasis to Liver</b>			INTERVAL BETWEEN ONSET AND DEATH <b>undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			<b>16ix</b>
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <b>6-27-59</b> to <b>6-29-59</b> and last saw <b>him</b> alive on <b>6-29-59</b> Death occurred at <b>4:10</b> <b>A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>J. W. Nofles M.D.</b> (Degree or title)	
22b. ADDRESS <b>2601 Whittier Street</b>		22c. DATE SIGNED <b>6-30-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>July 2-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson Barrack Mo.</b>
24. FUNERAL DIRECTOR <b>G. Wade Granberry 4202 Finney</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>JUN 30 59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <b>MJB</b>

**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 *Edward A. Flynn* .....

Licensed Embalmer No. **4444**.....

P. O. Address **4202 Finney**.....  
**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.