

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035319

FILED VS. OCT 19 1959

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1037

INDEXED

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|---|--|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> Length of stay in lb <u>47 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2819 So. 22nd Street</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2819 So. 22nd Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>OLLIE</u> Middle <u>KUKANDALL</u> Last <u>TYLER</u> | | | 4. DATE OF DEATH Month <u>October</u> Day <u>14</u> Year <u>1959</u> | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Caucasian</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/14/1890</u> | 9. AGE (last birthday) <u>69 yrs.</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Custodian</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mechanics Bank</u> | | 11. BIRTHPLACE (City and state or country) <u>DeKalb County, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Hamilton Tyler</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mrs. Frances Tyler</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>491-10-3194</u> | | 17. INFORMANT Address <u>2819 So. 22nd Street</u> <u>Mrs. Frances Tyler, St. Joseph, Mo.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u>Cholesterolemia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Mumps</u> | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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. Month, Day, Year _____ | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 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 <u>10-7-59</u> to <u>10-13-59</u> and last saw her/him alive on <u>10-12-59</u> Death occurred at <u>12:15 A.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>[Signature]</u> | | | 22b. ADDRESS <u>423 80th Ave</u> | | 22c. DATE SIGNED <u>10/14/59</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Oct. 16, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>St. Joseph, Funeral Home, St. Joseph, Mo., (6A5)</u> | | | 25. DATE RECD. BY LOCAL REG. <u>Dec 15, 1959</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Woodell</u> | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS
OCT 27 1959

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

Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph St

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.