

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-042510

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 324 Primary Registration District No. 30720 Registrar's No. 194

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
AMENDED

VS 300
Rev. 4/59

10975

20925

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Saline</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		c. CITY OR TOWN <u>Marshall</u>	
Length of stay in 1b <u>50 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gilliam Rest Haven</u>		d. STREET ADDRESS (If outside, give location) <u>343 East Arrow</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last			4. DATE OF DEATH Month Day Year
<u>MARIAN ELEANOR TYLER</u>			<u>November 6, 1963</u>
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>		<u>5-4-1884</u>
9. AGE (last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
<u>79</u>		<u>Ret. Bookkeeper</u>	
IF UNDER 1 YEAR Months Days Hours Min.		10b. KIND OF BUSINESS OR INDUSTRY	
		<u>Collectors Office Arrow Rock, Mo.</u>	
		11. BIRTHPLACE (City and state or country)	
		<u>USA</u>	
		12. CITIZEN OF WHAT COUNTRY	
		<u>USA</u>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
<u>William M. Tyler</u>		<u>Miranda Reid</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
<u>-----</u>		<u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
<u>-----</u>		<u>Mrs. William Bryan, Marshall, 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>Cerebral Hemorrhage & Hemiplegia 7 mo.</u>			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) _____			<u>7 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 checked="" 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>Feb. 63</u> to <u>Nov. 63</u> and last saw her <u>alive</u> on <u>9 pm.</u> Death occurred at <u>9 pm.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title)		22b. ADDRESS	22c. DATE SIGNED (State)
<u>[Signature]</u>		<u>Marshall Mo</u>	<u>11-8-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)
<u>Burial</u>	<u>11-8-1963</u>	<u>Ridge Park Cemetery</u>	<u>Marshall, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<u>Campbell-Lewis Marshall, Mo.</u>		<u>11-8-'63</u>	<u>[Signature]</u>

USE BLACK INK OR TYPEWRITER RIBBON

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

Phillip L. Smith

Licensed Embalmer No. 5163

P. O. Address Marshall, Mo.

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.