

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

35118

1. PLACE OF DEATH

County Franklin Registration District No. 64849 File No.
 Township Franklin Primary Registration District No. 64849 Registered No. 26
 City (No.) St. Ward)

2. FULL NAME

Andrew J. Tyler
 (a) Residence, No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 23 1922

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF widowed

17. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922, to Dec 23, 1922 that I last saw him alive on Dec 23, 1922, and that death occurred, on the date stated above, at 11:30 P. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-13-1840

THE CAUSE OF DEATH:* WAS AS FOLLOWS:
Acute Nephritis
130

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 9 10

(duration) yrs. mos. ds. 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work unborn
 (b) General nature of industry, business, or establishment in which employed (or employer) L
 (c) Name of employer L

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. L

10. NAME OF FATHER William Tyler

DID AN OPERATION PRECEDE DEATH. DATE OF 90

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ky

19. WAS THERE AN AUTOPSY? No

12. MAIDEN NAME OF MOTHER do not know

WHAT TEST CONFIRMED DIAGNOSIS? Gen Symptoms
 (Signed) W. C. Johnson, M. D.
Dec 23, 1922 (Address) Belle Mo

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

14. INFORMANT John L. Tyler
 (Address) Belle Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Jordan 2nd Dec 25 1922

15. FILED Jan 6 1923 Dora Jett
 REGISTRAR

20. UNDERTAKER John L. Tyler None ADDRESS Belle Mo

This certificate should be filled out in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

35118

1. PLACE OF DEATH
 City St. Louis Registration District No. 6440 File No. _____
 Precinct 11th St. & Olive Primary Registration District No. 8849 Registered No. 96
 County _____ State _____ Ward _____

2. FULL NAME Andrew J. Tyse
 (a) Residence No. _____ St. _____ Ward _____
 (Local place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
 4. COLOR OR RACE W
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF widowed

7. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-13-1840

8. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
82 9 10

9. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work retired
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

MEDICAL CERTIFICATE OF DEATH

10. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 23 1922
 11. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922 to Dec 23, 1922 that I last saw him alive on Dec 23, 1922 and that death occurred, on the date stated above, at 11:30 P.

THE CAUSE OF DEATH¹ WAS AS FOLLOWS:
Write Nephritis
130

CONTRIBUTORY (SECONDARY) _____
 (direction) yrs. mos. ds.

12. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF BIRTH _____

13. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Wife's symptoms
 (Signed) W. C. Johnson, M. D.
Dec 23, 1922 (Address) Belle Mo

¹State (1) DISEASE CAUSING DEATH, or in death from VIOLENT CAUSE, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

PARENTS

10. NAME OF FATHER William Tyse

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Key Ky

12. MAIDEN NAME OF MOTHER Talitha A. Sebastian

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT John Luther Belle Mo.
 (Address) _____

15. FILED Jan 6 1923 Dora Jett
 REGISTRAR

16. PLACE OF BURIAL, CREMATION, OR REMOVAL Jordan Mo

DATE OF BURIAL Dec 25 1922
 UNDERAKER John Luther Home Belle Mo
 ADDRESS _____

Item 12 amended by an affidavit from the great grand daughter 4-25-90