

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

Do not use this space.

10170

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1008**
City **St. Louis** **Everitt Ch Hospital**

File No.....
Registered No. **13070**
St. Ward)

2. FULL NAME

Tyng Livingston
(a) Residence. No. **6311 W. Park Ave.** St. **4** Ward.

(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 **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Rena Livingston**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **unknown**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
abt 50 - - -

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Carpenter**
(b) General nature of industry, business, or establishment in which employed (or employer) **Callahan Co.**
(c) Name of employer **W.C. 2177**

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Indiana**

10. NAME OF FATHER **unknown**

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

12. MAIDEN NAME OF MOTHER - - -

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) - - -

14. INFORMANT **H. E. Green**
(Address) **6311 W. Park Ave.**

15. FILED **MAR 30 1927** **man. b. Blaricoff**
19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Mar. 29** 19**27**

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
**Shock + Injuries of
Pneumonia + Head Injuries**

CONTRIBUTORY (COUNTRY) **France** (duration) **180**

18. WHERE WAS DISEASE CONTRACTED (NOT AT PLACE OF DEATH) **Accident / 180**

DID AN OPERATION PRECEDE DEATH? DATE OF WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS? (Signature) **R. J. ...** (Address) **Carroll**

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Topla Bluff Mo **3-31 1927**

20. UNDERTAKER ADDRESS
Southern N. T. Co **7315 S. Broadway**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

