PR 241[redacted]

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

Do not use this space.

10180

1. PLACE OF DEATH

County Dunklin — Registration District No. 290 — File No.

Township Salem — Primary Registration District No. 54-8 — Registered No. 18

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Troy Tylor

(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

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 11 1918

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	10	3	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) School Work

(c) Name of employer

261

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tate Co. Miss.

2

PARENTS

10. NAME OF FATHER Hermon Tylor

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

2

12. MAIDEN NAME OF MOTHER Percy Carlile

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

2

14. INFORMANT Hermon Tylor
(Address) Senath, Mo

15. FILED 4-1, 1929 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 3 1929

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1929, to March 3, 1929, that I last saw him alive on March 3, 1929, and that death occurred, on the date stated above, at 7 O'clock p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Nephritis

38

130

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Malaria

..... (duration) ..... yrs. 3 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature], M. D.

, 19 (Address)

*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
Senath Cemetery	Mar. 4 1929

20. UNDERTAKER	ADDRESS
McDaniel Jun Co	Senath Mo

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.