

DEC'D FEB 24 1939

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

2845

Do not use this space.

1. PLACE OF DEATH

(a) County Lafayette Registration District No. 464
 (b) Township Washington Primary Registration District No. 5626 Registered No. 2
 (c) City..... (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

600 Albert Tyree
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 30th 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 7 8

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lafayette Co. Mo.

FATHER 13. NAME Wm. P. Tyree

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

MOTHER 15. MAIDEN NAME Kate Powell

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

17. INFORMANT (ADDRESS) Albert Tyree Jr.
Mayview, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Higginsville DATE 1/9/39, 19..

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. H. Hader
Higginsville, Mo.

20. FILED 1-8, 19.. 39 Mrs. E. M. Gardner
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-7-39

22. I HEREBY CERTIFY, That I attended deceased from 1-2-, 1939, to 1-7-, 1939

I last saw him alive on 1-7-, 1939. Death is said

to have occurred on the date stated above, at 5 P. m.

The principal cause of death and related causes of importance were as follows:

Bronchial Pneumonia
Cerebral Embolus
J. W.

Date of onset

Other contributory causes of importance:

1) Myocarditis Chronic
2) Sclerosis Chronic

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19..

Where did injury occur?.....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) E. M. Gardner, M. D.(Address) Odessa, Mo.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10/13/39

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

Registered Apprentice No., working under my personal supervision

Signed *Arrest Riekhof*
.....
Licensed Embalmer No. 3637

P. O. Address Higginsville

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 this body is not embalmed, above space should be left blank.