

JAN 15 1940

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

43628
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 401
(b) Township Van Buren Primary Registration District No. 5536 Registered No. _____
(c) City _____ (d) Street No. Residence _____ 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

Mary B. Tyson
(a) Residence, No. Lone Jack Mo. R.F.D. - 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 Female 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 Dallas Tyson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July-12-1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
48 5 13

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife
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) Butler Mo. R.F.D.

FATHER 13. NAME Henry Brize
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown Ky

MOTHER 15. MAIDEN NAME Effie Clifton
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown Ky

17. INFORMANT (ADDRESS) Dallas Tyson Lone Jack Mo.

18. BURIAL, CREMATION, OR REMOVAL Less Summit Mo. DATE 12-27-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wells-James Less Summit Mo.

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec-25-1939

22. I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1939, to Dec 25, 1939
I last saw her alive on Dec 25, 1939. Death is said to have occurred on the date stated above, 9:30 P.M.
The principal cause of death and related causes of importance were as follows:

Primary Carcinoma of left breast

Date of onset 1938

Other contributory causes of importance: 50

Radical breast amputation
Name of operation _____ Date of May 1938
What test confirmed diagnosis? operation 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? no
If so, specify _____
(Signed) Cliff L. Miller M. D.
(Address) Less Summit, 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.

MISSOURI STATE BOARD OF HEALTH—BUREAU OF VITAL STATISTICS—A PERMANENT RECORD

1 X 14023

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..... *P. C. Fields*

Licensed Embalmer No. *2957*

P. O. Address *Leis Summit 7mo*

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

43628

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 401
 (b) Townshp San Buren Primary Registration District No. 5-5-26
 (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 Mary B Lyson

(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) W

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>48</u>	<u>5</u>	<u>13</u>	

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

FATHER

13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
 PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Dec. 27, 1989 Vernie E. Yankee
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 25, 1989

22. I HEREBY CERTIFY, That I attended deceased from to, 19.....
 I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at..... m.
 The principal cause of death and related causes of importance were as follows:
 Date of onset

Other contributory causes of importance:

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 Cholera
 (Signed) Clint L. Milley, M. D.
 (Address) Missouri

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PEYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE. DESCRIBED BY LAW.

