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DEPARTMENT OF COMMERCE **FILED JUN 25 1941** MISSOURI STATE BOARD OF HEALTH  
BUREAU OF THE CENSUS **1003**  
STANDARD CERTIFICATE OF DEATH

16895  
State File No. \_\_\_\_\_  
Registrar's No. **4413**

Registration District No. **791** Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town **St. Louis**  
(c) Name of hospital or institution:  
**245 N. Union Blvd.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME **Sophie Tuyn**  
3. (b) If veteran, name war **No.** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **James A.** 6. (c) Age of husband or wife if alive **33** years  
7. Birth date of deceased **Aug. 19 1917**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**23 9 7** hr. min.

9. Birthplace **Tarrytown / New York**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **John Tidabank**  
13. Birthplace **Tarrytown / New York**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Unknown**  
15. Birthplace **Unknown 9**  
(City, town, or county) (State or foreign country)

16. (a) Informant **J. A. Tuyn**  
(b) Address **Buffalo, N.Y.**

17. (a) **Removal** (b) Date thereof **5/26/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Williamsville, N.Y.**

18. (a) Signature of funeral director **Albert H. Hoppe**  
(b) Address **4700 Washington Blvd.**

19. (a) **MAY 26 1941** (b) **J. N. Brudack**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Michigan** (b) County **Wayne**  
(c) City or town **Detroit**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **15034 Ardmore**  
(If rural, give location) \_\_\_\_\_  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **May** day **26th**  
year **1941** hour **8** minute **21 a.m.**

21. I hereby certify that I attended the deceased from **May 26**, 19**41**, to **May 26**, 19**41**; that I last saw her alive on **May 26**, 19**41**; and that death occurred on the date and hour stated above.

Immediate cause of death  
**Respiratory paralysis  
Complicating Myasthenia Gravis**

Due to \_\_\_\_\_  
Duration \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy **none**  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **Victor E. Sherman** (M. D. or other) **O**  
Address **508 Nostrand** Date signed **5-26-41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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

*Guy W Wilkinson*

Licensed Embalmer No.....

3575

P. O. Address.....

**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, fact should be so stated above.**