S. No. 2
M—2-43
. 5-17-39
I X35897

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

3782

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED FEB 21 1946

Registration District No. 13

Primary Registration District No. 4056

State File No. 4759

Registrar's No. 51

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Fisk
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: —
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution —
(Specify whether
In this community 25 years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Butler 12

(c) City or town Fisk 0
(If outside city or town limits, write "RURAL")

(d) Street No. — 0
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Martha Annie Tyree

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex F. 1

5. Color or race W.

6. (a) Single, widowed, married, divorced M. 1

6. (b) Name of husband or wife Lafe Tyree

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Sept. (Month) 21 (Day) 1880 (Year)

8. AGE: Years 65 | Months | Days | If less than one day ___ hr. ___ min.

9. Birthplace (City, town, or county) Illinois (State or foreign country) 1

10. Usual occupation Housewife.

11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace (City, town, or county) " (State or foreign country) 9

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) " (State or foreign country) 9

16. (a) Informant Orina Roberts
(b) Address Fisk, Mo.

17. (a) B. (Burial, cremation, or removal) (b) Date thereof 2-7-46 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Vale Cemetery

18. (a) Signature of funeral director Lloyd Russell
(b) Address Piggott Ark.

19. (a) 2/16/46 (Date received local registrar) (b) R H Minetree (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 5
year 46 hour ___ minute ___ M.

21. I hereby certify that I attended the deceased from 12/19, 1945, to 2/1, 1946, that I last saw her alive on 1/22, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Left [illegible] Duration

Due to Chronic Myocarditis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 938

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?
(Specify type of place)

While at work? (e) Means of injury 2

23. Signature [illegible] (M.D. or other) DO

Address Fisk Mo. Date signed 2/1/46

(Licensed Embalmer's Statement on Reverse Side)

Dr. Wemphill
Fisk, Mo.

RECEIVED
District Health Office No. 2,
District File Number 246-252
Date Filed 2-20-46

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.....

Licensed Embalmer No.....

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.