

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **384717E**FILED NOV 24 1947
Registration District No. **779**Primary Registration District No. **1002**Registrar's No. **4730**

1. PLACE OF DEATH:

(a) County **Jackson**
Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5109 Wyandotte
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **no.** (Specify whether
In this community **20 years**
years, months or days)

3. (a) PRINT FULL NAME **Bertram Tizard**3. (b) If veteran, name war **no.** 3. (c) Social Security No. **no.**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Mrs. Lillian Tizard** 6. (c) Age of husband or wife if alive **57** years
7. Birth date of deceased **April 20 1880**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 6 20 hr. min.9. Birthplace **England**
(City, town, or county) (State or foreign country)10. Usual occupation **Retired**11. Industry or business **X**12. Name **William Tizard** 4
13. Birthplace **England** 4
(City, town, or county) (State or foreign country)14. Maiden name **Sarah Griffin**
15. Birthplace **England** 4
(City, town, or county) (State or foreign country)16. (a) Informant **Mrs. Lillian Tizard,**(b) Address **5109 Wyandotte, Kansas City, Mo.**17. (a) **burial** (b) Date thereof **11-13-47**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **MT MORIAH**18. (a) Signature of funeral director **Stine & McClure**(b) Address **3235 Gillham Plaza, Kansas City, Mo.**19. (a) **11-12-47** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** 48
(c) City or town **Kansas City** 3
(If outside city or town limits, write "RURAL")
(d) Street No. **5109 Wyandotte** 8
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country **X**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **10**
year **1947** hour **10:45** minute **P.** M.21. I hereby certify that I attended the deceased from **Aug 1943**
to NOV 10 1947
that I last saw him alive on **NOV 10 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral apoplexy** 1 day
Cerebral arterial sclerosis and hypertension 14 yrs
Due to **Cerebral arterial sclerosis and hypertension**
Due to **hypertension**

Other conditions.
(Include pregnancy within 3 months of death)

Major findings:
Of operations **850**
Of autopsy **0**

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? **0**
(Specify type of place) Means of injury _____
23. Signature **C. P. Gilles** (M. D. or _____)
Address **1414 Prof Bld** Date signed **11/14/47**

Tracy Bledsoe

Dr. Gilles

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

J. Clair Sheppard

Licensed Embalmer No. *4159*

P. O. Address *K. C. Ind.*

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.