

No. 2  
8-43  
5-17-39  
37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42365

State File No. \_\_\_\_\_

FILED JAN 5 1948

Registration District No. 209

Primary Registration District No. 4320

Registrar's No. 75

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Palmyra  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Liberty township /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 3 years (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion <sup>67</sup>  
(c) City or town Palmyra <sup>2</sup>  
(If outside city or town limits, write "RURAL") <sup>0</sup>  
(d) Street No. \_\_\_\_\_ (If rural, give location) <sup>0</sup>  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 17  
year 1947 hour 11 minute 0 P.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1947, to Dec. 15, 1947.  
that I last saw him alive on Dec. 15, 1947,  
and that death occurred on the date and hour stated above.

Immediate cause of death Hemiplegia Duration \_\_\_\_\_

Due to A poplexy  
Due to Chronic endocarditis and chronic nephritis  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_

(a) Signature of funeral director \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(b) Address Palmyra Mo. (c) Means of injury \_\_\_\_\_  
(d) Signature W. B. ... (M. D. or other) \_\_\_\_\_  
(e) Address Palmyra Mo. Date signed 12/19/47

3. (a) PRINT FULL NAME William Lawrence Tyler

3. (b) If veteran, name war No. 3. (c) Social Security No. No.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Florence Tyler 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 1 1874  
(Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Marion County, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Taxider

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

12. Name Sam Tyler

13. Birthplace Missouri (City, town, or county) (State or foreign country)

14. Maiden name Sarah Gross (State or foreign country)

15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Florence Tyler

(b) Address Palmyra, Mo.

17. (a) Burial (b) Date thereof 12/20/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Palmyra Cemetery

18. (a) Signature of funeral director Lewis Brown

(b) Address Palmyra Mo.

19. (a) 12-22-47 (b) Verla Sec. Deputy  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

19.47

**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..... *Robert Lewis*

Licensed Embalmer No. *2382*

P. O. Address *Palmyra, Mo*

**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.**

Registration District No. 209 Primary Registration District No. 4320

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(a) County Marion  
(b) City or town Palmyra  
(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 \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Wm. J. Tyler  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 73 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation Shower

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

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Wm. Lucke (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1947 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

42365