

No. 300
4-10-47
5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31582**

FILED OCT 4 1948
Registration District No. **2948**

Primary Registration District No. **3066**

Registrar's No. **2158**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
96
4
3

1. PLACE OF DEATH:
(a) County **St Louis**
(b) City or town **St. Kirkwood Mo**
(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 **Life time** years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **St. Louis**
(c) City or town **Kirkwood** (If outside city or town limits, write "RURAL")
(d) Street No. **421 So. Harrison** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Molly Tyler**
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **14** year **1948** hour **6** minute **00** A.M.
21. I hereby certify that I attended the deceased from **10 Mar.** 1947, to **14 Sept.** 1948, that I last saw him alive on **13 Sept.** 1948, and that death occurred on the date and hour stated above.

4. Sex **F** 3 5. Color or race **nepe**
6. (a) Single, widowed, married, divorced **2**
(b) Name of husband or wife **Samuel Tyler** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **7/16-1861** (Month) (Day) (Year)

Immediate cause of death **Carcinoma (Cervix)** Duration **2 yrs**
Due to **unknown** 4 8 hrs
Due to **unknown**
Other conditions **Industrious** (Include pregnancy within 3 months of death)

8. AGE: Years **87** Months **1** Days **28** If less than one day hr. min.
9. Birthplace **Robertsville Mo** (City, town, or county) (State or foreign country)
10. Usual occupation **House wife**

Major findings: Of operations **None**
Of autopsy **None**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
11. Industry or business _____
12. Name **Unknown**
13. Birthplace **Mo** (City, town, or county) (State or foreign country)
14. Maiden name **Molly Porter**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)
16. (a) Informant **Maude Talbot**
(b) Address **421 S Harrison Kirkwood**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Sept. 18-48** (Month) (Day) (Year)
(c) Place: burial or cremation **Father Dickson**
18. (a) Signature of funeral director **Susie Lewis**
(b) Address **22 Euclid Webster Grove**
19. (a) **9-17-48** (Date received local registrar) (b) **Geed a J. Hays** (Registrar's signature)

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 **J. H. Bennett** (M. D. or other) **MD**
Address **289 W. Jefferson** Date signed **9/14/48**

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 *E.T.D. Richards*

Licensed Embalmer No. *2928*

P. O. Address *2625 Glasgow*

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.