

FILED JUL 11 1949

STANDARD CERTIFICATE OF DEATH

State File No. 20018

BIRTH NO. _____ REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 5586 Registrar's No. 113

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give town) "Rural" Marion		c. CITY (If outside corporate limits, write RURAL and give township) "Rural" Marion	
c. LENGTH OF STAY (in this place) 68 yrs.		d. STREET ADDRESS (If rural, give location) Carthage Route #2	
d. FULL NAME OF HOSPITAL OR INSTITUTION Carthage Route #2		d. STREET ADDRESS (If rural, give location) Carthage Route #2	

3. NAME OF DECEASED (Type or Print) a. (First) Daniel b. (Middle) Sheakspeare c. (Last) TRYON			4. DATE OF DEATH (Month) (Day) (Year) June 25, 1949		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 3, 1871		9. AGE (In years last birthday) 77 IF UNDER 1 YEAR Months 9 IF UNDER 12 HRS. 22 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Raub, Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME William Tryon		13b. MOTHER'S MAIDEN NAME Margaret Schaefer		14. NAME OF HUSBAND OR WIFE Mrs. Emily Wheeler Tryon	
---	--	--	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Emily Tryon ADDRESS Route #2 Carthage, Mo.	
---	--	-------------------------------------	--	---	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure - (1 week)						1 week		
* This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.			ANTECEDENT CAUSES					
			DUE TO (b) Myocardial weakness - (1 year)			1 Year		
			DUE TO (c)					
			II. OTHER SIGNIFICANT CONDITIONS			4222		
			Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
------------------------	--	----------------------------------	--	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 13, 1949, to June 25, 1949, that I last saw the deceased alive on June 25, 1949 and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. Russell Smith M.D.		23b. ADDRESS Carthage, Missouri		23c. DATE SIGNED 6-27-49	
---	--	--	--	---------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-28-1949		24c. NAME OF CEMETERY OR CREMATORY Park Cemetery		24d. LOCATION (City, town, or county) (State) Carthage, Mo.	
---	--	----------------------------	--	---	--	--	--

DATE REC'D BY LOCAL REG. 6-28-1949		REGISTRAR'S SIGNATURE L. B. Clinton		25. FUNERAL DIRECTOR'S SIGNATURE Ed. C. Ulmer ADDRESS Carthage, Mo.	
---	--	--	--	---	--

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

RECEIVED 7-5-49

Jasper County Health Office

County File Number 49-6-505

Date Filed 7-9-49

JUL 13 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *John S. Penney*

Licensed Embalmer No. 4194

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.