

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013721

STATE FILE NUMBER

FILED APR 21 1959 Registration District No. 146 Primary Registration District No. 5-5-69 Registrar's No. 165

300  
-57

1. PLACE OF DEATH a. COUNTY Jackson (Boasting)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY JAC KSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 10014 E 47st		d. STREET ADDRESS (If outside, give location) 10014 E 47st	

3. NAME OF DECEASED (Type or print) First Middle Last Robert C. TYSON			4. DATE OF DEATH Month Day Year April 9 1959			
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25-1870	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during no. of working years or retired) CARPENTER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ATLANTA, Georgia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE Cecil D. Tyson	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Wm. Seibold 10014 E 47st
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia		INTERVAL BETWEEN ONSET AND DEATH 1 week
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) _____		
DUE TO (c) Carcinoma of lung		1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 16 3x		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 4 April 59 to 9 April and last saw him alive on 9 April 59  
Death occurred at 8:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Jack M. Davis M.D.	22b. ADDRESS Raytown, Mo.	22c. DATE SIGNED 10 Apr 59
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4/11/59	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah	23d. LOCATION (City, town, or county) (State) KANSAS CITY Mo.
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24. FUNERAL DIRECTOR Keple; Hinton	ADDRESS Raytown, Mo	25. DATE RECD. BY LOCAL REG. 4-11-59	26. REGISTRAR'S SIGNATURE James S. Kelly
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 .....  
Signature of Student Embalmer

Signed *John P. DeLeon* .....  
Licensed Embalmer No. *453* .....  
P. O. Address *Kansas City* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.