

062619

HEALTH DEPARTMENT--CITY OF BALTIMORE

062619

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: No. *Mayland Eye Hosp* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Robert H. Tyson*

(Residence in Baltimore: No. *Rising Sun Md* St. *45* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX *Male*

4-COLOR OR RACE *White*

5-SINGLE MARRIED *Married*
WIDOWED
OR DIVORCED
(Write the word)

13-DATE OF DEATH *March 14* 191*3*

(Month) (Day) (Year)

6-DATE OF BIRTH *March* 1, 1868

(Month) (Day) (Year)

7-AGE *45* yrs. *0* mos. *13* ds. or min.?

If LESS than 1 day, hrs. min.?

17- I HEREBY CERTIFY, That I attended deceased from *Mar 4* 191*3*, to *March* 191*3*, that I saw him alive on *Mar 14* 191*3*, and that death occurred, on the date stated above, at *1:00 a.m.*

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

8-OCCUPATION *Lawyer*

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE *Md.*

(State or country)

10-NAME OF FATHER *Samuel Tyson*

11-BIRTHPLACE OF FATHER *Md.*

12-MAIDEN NAME OF MOTHER *Jane M. Jarney*

13-BIRTHPLACE OF MOTHER *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Bertha M. Tyson*

(Address) *Rising Sun Md.*

Contributory (SECONDARY)

(Signed) *C.F.W. Snyder* M. D. *Md 14 1913* [Address] *Md New Hope*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. *10* ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death? *Rising Sun Md*

Former or usual residence *Rising Sun Md.*

19-PLACE OF BURIAL OR REMOVAL *Colona Md*

DATE OF BURIAL *Mar. 17* 191*3*

UNDERTAKER *Mear & Jones*

ADDRESS *833 Linden av*

15-

Filed *3/15* 191*3*

HARRY O. ANDREWS,

Marial Permit Clerk

REGISTRAR

Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.