

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37103
Registrar's No. 1804

Registration District No. 784 Primary Registration District No. 161

1. PLACE OF DEATH:
(a) County Clayton
(b) City or town Clayton
(c) Name of hospital or institution: St. Louis Co. Hosp.
(d) Length of stay: In hospital or institution. 1 day
In this community 3 Month
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Clayton Mo.
(d) Street No. 8333 N. Broadway
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Michael Kyle
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Child
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 12 1939
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>3</u>	<u>1</u>	hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Volney Kyle
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Dores Kate MURPHY
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Volney K. Kyle
(b) Address 8333 N. Broadway

17. (a) Burial (b) Date thereof Oct 15, 1939
(Burial, cremation, etc.) (City, town, or county) (State or foreign country)

(c) Place: burial or cremation Berme Mo.
18. (a) Signature of funeral director Diedrich F. Home
(b) Address 6319 Halls Ferry Rd.

19. (a) OCT 14 1939 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 13
year 1939 hour 5 minute 30 PM.

21. I hereby certify that I attended the deceased from _____, 19____, 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 _____

Volvulus
Due to _____
Intestinal obstruction
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 2/3 of Ileum gangrenous

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)
(a) Means of injury _____
23. Signature John O. Knell (M. D. or other) _____
Address Coroner of St. Louis County mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

Gary W. Wilkinson

.....Licensed Embalmer No.....

3575

.....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, above space should be left blank.