

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.

JAN 17 1940

# MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

44164

Do not use this space.

1. PLACE OF DEATH  
 (a) County Mo. 1 Registration District No. 622  
 (b) Township Graham Primary Registration District No. 4373  
 (c) City St. Louis (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 400  
 2. PRINT FULL NAME Samuel Anderson Lyle  
 (a) Residence, No. St. [ ] (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Miss Cora Everhart Lyle</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug 15 1876</u>		
7. AGE <u>63</u>	YEARS <u>63</u>	MONTHS <u>3</u>
DAYS <u>24</u>		IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u> 9. Industry or business in which work was done, as saw mill, bank, etc. 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation		
12. BIRTHPLACE (CITY OR TOWN) <u>Graham</u> (STATE OR COUNTRY) <u>Missouri</u>		
FATHER 13. NAME <u>James R. Lyle</u> 14. BIRTHPLACE (CITY OR TOWN) <u>Graham</u> (STATE OR COUNTRY) <u>Illinois</u>		
MOTHER 15. MAIDEN NAME <u>Mary Gillis</u> 16. BIRTHPLACE (CITY OR TOWN) <u>Graham</u> (STATE OR COUNTRY) <u>Vermont</u>		
17. INFORMANT (ADDRESS) <u>Hugh Lyle</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Graham</u> DATE <u>Dec 12 1939</u>		
19. FUNERAL DIRECTOR (NAME) <u>Emmett Funeral Home</u> (ADDRESS) <u>251 South Main, Marshall, Mo.</u>		
20. FILED <u>Jan 14 1940</u> <u>Wm. O. Black</u> Local Registrar		

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>Dec 9</u> , 19 <u>39</u>
22. I HEREBY CERTIFY, That I attended deceased from <u>Dec 9</u> , 19 <u>39</u> , to <u>Dec 9</u> , 19 <u>39</u> . I last saw him alive on <u>Dec 9</u> , 19 <u>39</u> . Death is said to have occurred on the date stated above, at <u>11:45 P.M.</u> The principal cause of death and related causes of importance were as follows: <u>Paralysis Hemiplegia</u> <u>Lobar Pneumonia</u> Other contributory causes of importance: Name of operation <u>none</u> Date of <u>none</u> What test confirmed diagnosis? <u>none</u> Was there an autopsy? <u>no</u> 23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? <u>none</u> Date of injury <u>none</u> , 19 <u>39</u> Where did injury occur? <u>none</u> (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place. Manner of injury <u>none</u> Nature of injury <u>none</u> 24. Was disease or injury in any way related to occupation of deceased? If so, specify <u>no</u> (Signed) <u>E. L. Morgan</u> M. D. (Address) <u>Graham, Mo.</u>

RECEIVED

District Health Officer No. 11;

District File Number 140-1987

Date Filed JAN 16 1940

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.....

*William Campbell*....., Registered Apprentice No.....  
working under my personal supervision.

Signed *William Campbell*.....

Licensed Embalmer No. *2620*

P. O. Address *Maryville Mo*

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.