

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH: R000  
(a) County 2  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
930 Russell Blvd.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
years, months or days) 2 mo. 7 days

3. (a) PRINT FULL NAME Martha Ellen Kuyrkendall 625  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Singel  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: October 25, 1939  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 2 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Hiram Kuyrkendall  
13. Birthplace West Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Frances Belyed  
15. Birthplace Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. B. Kuyrkendall  
(b) Address 930 Russell Blvd.

17. (a) Burial (b) Date thereof 1/2/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Orchard Hill Louisville, Ill.

18. (a) Signature of funeral director Wacker-Weldner  
(b) Address 2331 S. Broadway

19. (a) JAN 22 1940 (b) JO B. B. B.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 1  
(c) City or town St. Louis 23  
(If outside city or town limits, write "RURAL")  
(d) Street No. 930 Russell  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 2  
year 1940 hour 1 minute 30 p. M.

21. I hereby certify that I attended the deceased from Oct 25, 1939 to Nov 17, 1939 that I last saw her alive on Nov 17, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Hydrocephalus  
Spina Bifida  
Due to Congenital Spina Bifida  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 or place)  
23. Signature Samuel S. ...  
Address 3720 Washington Date signed 1/2/40

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
Rev. 5-17-39 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 Frank J. Wyland Jr.

Licensed Embalmer No. 2645

P. O. Address St Louis 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.**