

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1502
462

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson,

(b) City or town Kansas City,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3655 Summit Street,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no.
(Specify whether years, months or days)

In this community since 1909,

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Jackson,

(c) City or town Kansas City,
(If outside city or town limits, write "RURAL")

(d) Street No. 3655 Summit St.,
(If rural, give location)

(e) If foreign born, how long in U. S. A. no. years.

3. (a) PRINT FULL NAME Charles Alfred Hyle,

3. (b) If veteran, name war no. 3. (c) Social Security No. 486-01-0406

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married,

6. (b) Name of husband or wife Carrie Munns Hyle 6. (c) Age of husband or wife if alive no. years

7. Birth date of deceased April 7 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>9</u>	<u>24</u>	hr. min.

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

10. Usual occupation Retired, Executive

11. Industry or business Dairy

12. Name William Edward Hyle,

13. Birthplace Ohio,
(City, town, or county) (State or foreign country)

14. Maiden name Geiser,

15. Birthplace Ohio,
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Dorothea F. Hyle,

(b) Address 3655 Summit St., Kansas City, Mo.

17. (a) Burial (b) Date thereof 2-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) Jan 21 1941 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 31st
year 1941 hour 2:00 minute A. M.

21. I hereby certify that I attended the deceased from 12-21-39, 1939, to Jan 31, 1941;
that I last saw him alive on Jan 30, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Arterial reorganization

Due to do not know

Due to BIB

Other conditions Nephritis Chronic
(Include pregnancy within 6 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 of place) (c) Means of injury D

23. Signature James W. Graham (M. D. or other)

Address 1518 Argyle Bldg. R.P. Co. Date signed 1-31-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Jas. Graham,
Annapolis, Md. 5676

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: *E. M. Plack*

Licensed Embalmer No. *1848*

P. O. Address *T. C. 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, fact should be so stated above.