DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 8 1944

Registration District No. 1

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24977

Primary Registration District No. 5596

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Desoto Rural (Valle) Tr
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location) 1

(d) Length of stay: In hospital or institution (Specify whether

In this community 54 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jefferson

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

(d) Street No. 3 mi South of Desoto
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME CHARLES THOMAS KYLE

3. (b) If veteran, name war World war

3. (c) Social Security No. —

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Mary Kyle

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased March 22 1890
(Month) (Day) (Year)

8. AGE: Years 54 Months 2 Days 9 If less than one day ___ hr. ___ min.

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

10. Usual occupation Farmer

11. Industry or business —

FATHER
12. Name Lige Kyle
13. Birthplace Hillsboro (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Cora Ogle
15. Birthplace Hillsboro (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Mrs. Thomas Kyle

(b) Address Desoto Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3 1944 (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Donnell B. Dietrich

(b) Address Desoto Mo.

19. (a) 7-25-44 (Date received local registrar) (b) Fern Spencer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1 year 1944 hour 10 minute 9 M.

21. I hereby certify that I attended the deceased from ___, 19___, to ___, 19___;
that I last saw h___ alive on ___, 19___;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Unknown Natural Causes	
Due to Hemorrhage	?
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 1

(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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Donnell B. Dietrich 3 Coroner Jeff Co (M.D. or other)

Address Desoto Mo. Date signed June 3 1944

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 8-4-44

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.....

Licensed Embalmer No. 9104

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 163 Primary Registration District No. 5596 Registrar's No. 50

1. PLACE OF DEATH:

(a) County Jefferson

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

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Charles J. Kyle

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March (Month) 22 (Day) 1890 (Year)

8. AGE: Years 54 Months 2 Days 9 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Unknown Natural Causes

Due to Hemorrhage

Due to Not known

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

SUPPLEMENTARY

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Neither

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Donald B. Dietrich (M.D.) Coroner

Address Desoto Mo Date signed Aug 18, 1944

24977