

S. No. 2
OM-8-43
v. 5-17-39
I X37823

DEPARTMENT OF HEALTH - THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CERTIFICATE OF DEATH
FILED NOV 6 1946 STANDARD CERTIFICATE OF DEATH

State File No. **32916**
Registrar's No. **356**

Registration District No. **47** Primary Registration District No. **3008**

1. PLACE OF DEATH:
(a) County **Callaway**
(b) City or town **Fulton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **State Hospit No 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **71 days**
In this community **Same**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Ohio** (b) County **Ct. Louis**
(c) City or town **Wellston**
(If outside city or town limits, write "RURAL")
(d) Street No. **1520-a Bugel hollow**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **L LEAVER PYLE**
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **29** year **1946** hour minute M.
21. I hereby certify that I attended the deceased from **10-19-46** to **10-29-46**
that I last saw him, alive on **10-29-46** and that death occurred on the date and hour stated above.

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **M.**
6. (b) Name of husband or wife **Eva** 6. (c) Age of husband or wife if alive **D. K.** years
7. Birth date of deceased **10 27 1864**
(Month) (Day) (Year)

Immediate cause of death **Chronic Myocarditis**
Duration

8. AGE: Years **82** Months **2** Days **2** If less than one day hr. min.

Due to
Due to
Other conditions (include pregnancy within 3 months of death)

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

Major findings: **93D**
Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

10. Usual occupation **brick layer**

11. Industry or business

12. Name **Thomas L. Pyle**

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

14. Maiden name **house vale**

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

16. (a) Informant **Records**

(b) Address **State Hop. No 1**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Oct 29-46**
(Month) (Day) (Year)

(c) Place: burial or cremation **St Louis mo.**
18. (a) Signature of funeral director **Wallace Funeral Home**
(b) Address **Fulton mo**
19. (a) **10-29-1946** (b) **Josie Morisick Hoff**
(Date received local registrar) (Registrar's signature)

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
Signature **A. P. Price** (M. or Dr.)
Address **Fulton Mo 10/29/46**
FUEX

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

4
1
2

SEAL

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 11/6/36

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 *John Ketter*
Licensed Embalmer No. *3880*
P. O. Address *St Louis*

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: