S. No. 2
M—1/47
r. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35965

FILED NOV 7 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9981

1. PLACE OF DEATH:
(a) County
(b) City or town ST LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution PARK LANE HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County JEFF. 50
(c) City or town DE SOTO 2
(If outside city or town limits, write "RURAL")
(d) Street No. 708 N. 5th 2
(If rural, give location) N.R. 9
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ALFRED EDWARD KYLE JR.
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 —
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Oct (Month) 28 (Day) 1947 (Year)

8. AGE: Years —, Months —, Days —, If less than one day 2 hr. 45 min.

9. Birthplace PARK LANE ST LOUIS (City, town, or county) Mo (State or foreign country)
10. Usual occupation —
11. Industry or business —

FATHER
12. Name ALFRED E. KYLE SR.
13. Birthplace DE SOTO (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name CATHERINE WASHBURN
15. Birthplace DE SOTO (City, town, or county) Mo. (State or foreign country)

16. (a) Informant ALFRED KYLE
(b) Address DE SOTO Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct 29/47 (Month) (Day) (Year)
(c) Place: burial or cremation DE SOTO Mo
18. (a) Signature of funeral director [illegible]
(b) Address DeSoto Mo
19. (a) OCT 29 1947 (Date received local registrar) (b) J. F. Breuer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28 year 1947 hour 11 minute 15 P.M.
21. I hereby certify that I attended the deceased from 10/28/47, 19..., to 10/28/47, 19...; that I last saw him alive on 10/28/47, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Atelectasis	2 hr.
Due to: Prematurity	45 min
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations	
Of autopsy	

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

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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature G. William Poehl M.D. (M. D. or other)
Address 5101 Delmar St. Date signed 10/29/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side) G. William Poehl

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.

NOT EMBALMED

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.