

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11465

State File No. ....

FILED MAR 29 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 692

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY OR TOWN <u>Koch, Missouri</u>	c. LENGTH OF STAY (In this place) _____	c. CITY OR TOWN <u>St. Louis</u> <u>2069</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Kild Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>4975 Wabada</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Gerald</u>	b. (Middle) <u>(H)</u>	c. (Last) <u>Mc Kye</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>3 14 1952</u>
-------------------------------------	--------------------------	------------------------	-------------------------	---

5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>11-18-02</u>	9. AGE (In years last birthday) <u>49</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	----------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>port office clerk</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>hospital department</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri; St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	--	---	--

13a. FATHER'S NAME <u>Patrick Mc Kye</u>	13b. MOTHER'S MAIDEN NAME <u>Ann Fitzgerald</u>	14. NAME OF HUSBAND OR WIFE _____
--	---	-----------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Blair J. Munson, M.D.</u>	ADDRESS <u>Koch, Missouri</u>
---	-------------------------------------	--	-------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>ca 1 year</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>pulmonary tuberculosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>secondary anemia</u>			

19a. DATE OF OPERATION <u>✓</u>	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---------------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
--	--	----------------------------------

22. I hereby certify that I attended the deceased from 3-7, 1952 to 3-14, 1952, that I last saw the deceased alive on 3-13, 1952, and that death occurred at 3:45 am, from the causes and on the date stated above.

23a. SIGNATURE <u>Bernard Sullivan, M.D.</u>	(Degree or title) _____	23b. ADDRESS <u>Koch Hosp., Koch Mo.</u>	23c. DATE SIGNED <u>3-14-52</u>
--	-------------------------	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>3/17/52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem. St. Louis Mo</u>	24d. LOCATION (City, town, or county) (State) _____
---	--------------------------	---	---

DATE REC'D BY LOCAL REG. <u>3-15-52</u>	REGISTRAR'S SIGNATURE <u>Robert R. Donke MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>SULLIVAN'S</u>	ADDRESS <u>28497 Euclid City</u>
---	---	--	----------------------------------

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

**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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Robert L. Brinkman* 6

Licensed Embalmer No. *3553*

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, fact should be so stated above.