

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27213**
Registrar's No. **887**

ED **AUG 25 1952**
BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

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

| | | | |
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| 1. PLACE OF DEATH a. COUNTY Buchanan 0117 | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan 0117 | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph | c. LENGTH OF STAY (in this place) 62 Yrs | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital | | d. STREET ADDRESS (If rural, give location) 3004 Olive Street | |

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|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) JESSIE b. (Middle) V. c. (Last) KYLE | | | 4. DATE OF DEATH (Month) (Day) (Year) August 18- 1952 | | |
|---|--|--|--|--|--|

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|----------------------|-------------------------------|---|--------------------------------------|--|---|-----------------------|---------------------|----------------------|---------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH April 4-1864 | | 9. AGE (In years last birthday) 88 Yrs | # UNDER 1 YEAR Months | # UNDER 1 YEAR Days | # UNDER 1 YEAR Hours | # UNDER 1 YEAR Min. |
|----------------------|-------------------------------|---|--------------------------------------|--|---|-----------------------|---------------------|----------------------|---------------------|

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|--|--|--|--|---|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housework at home | | 11. BIRTHPLACE (State or foreign country) Binghamton, New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
|--|--|--|--|---|--|--|--|

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|--|--|--|--|--|--|
| 13a. FATHER'S NAME Henry Hungerford | | 13b. MOTHER'S MAIDEN NAME Harriett Carter | | 14. NAME OF HUSBAND OR WIFE William W. Kyle | |
|--|--|--|--|--|--|

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|--|-------------------------------------|---|--|--------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. none | 17. INFORMANT'S SIGNATURE OR NAME Mrs. H. J. Enright, (Daughter) | | ADDRESS Faraon St. City | |
|--|-------------------------------------|---|--|--------------------------------|--|

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| 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary edema | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial insufficiency | | | | 3 days |
| | DUE TO (c) arterio-sclerosis - gen. central | | | | many yrs |
| | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. fract. of hip, fract. shaft of femur | | | | 11 yrs, 6 days |

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|---------------------------------------|--|--|--|--|--|
| 19a. DATE OF OPERATION 8/15/52 | 19b. MAJOR FINDINGS OF OPERATION Compound fracture of shaft of r. femur - lower 2/3 - open reduction | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 21a. ACCIDENT (Specify) SUICIDE HOMICIDE Accident | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home (nursing) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Joseph Buchanan Missouri | |
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|---|---|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-12-52 8:00a.m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? Fell out of bed. 4221 F. | |
|---|---|--|--|

22. I hereby certify that I attended the deceased from **4/17, 1950** to **8/18, 1952** that I last saw the deceased alive on **8/18, 1952** and that death occurred at **7:05p m.**, from the causes and on the date stated above.

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|---|--|---|--|---------------------------------|--|
| 23a. SIGNATURE G. T. Bloomer, M.D. | | 23b. ADDRESS 1218 N. 3rd St. St. Joseph, Mo. | | 23c. DATE SIGNED 8/20/52 | |
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|---|---------------------------------|--|---|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE August 20/1952 | 24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | 24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri | | |
|---|---------------------------------|--|---|--|--|

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|--|---|-----|---|--------------------------------|--|
| DATE REC'D BY LOCAL REG. Aug 22, 1952 | REGISTRAR'S SIGNATURE Carl C. Casper | 446 | 25. FUNERAL DIRECTOR'S SIGNATURE Walter H. Hines | ADDRESS St. Joseph, Mo. | |
|--|---|-----|---|--------------------------------|--|

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 _____

.....
working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed

Raymond H. Morehead

Licensed Embalmer No. # 4213

P. O. Address St. Joseph, Missouri.

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.