

STANDARD CERTIFICATE OF DEATH

3375

State File No. _____

FILED FEB 11 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1067**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 2511 N. Prairie Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) LUCY b. (Middle) Roberts c. (Last) Kyle		4. DATE OF DEATH (Month) (Day) (Year) January 24, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 5, 1915
9. AGE (In years last birthday) 37		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Missouri
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY At Home	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Sidney Atchison		13b. MOTHER'S MAIDEN NAME Ellen Francis Shaffer	14. NAME OF HUSBAND OR WIFE Carl
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. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Carl Kyle, 2511 N. Prairie Ave.
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) Eclampsia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pregnancy DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 6423	
22. I hereby certify that I attended the deceased from January 23, 1953 , to January 24, 1953 , that I last saw the deceased alive on January 24, 1953 , and that death occurred at 10:00 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE <i>George E. Smith, M.D.</i>		23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 1-26-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-25-53	24c. NAME OF CEMETERY OR CREMATORY Bernie	24d. LOCATION (City, town, or county) (State) Bernie, Mo.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 29 1953 <i>J. Earl Smith, M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.		

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

(Licensed Embalmer's Statement on Reverse Side)

FEB 11 1953

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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. Wilkinson

Licensed Embalmer No. 3575

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.