

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10353**  
**2298**

BIRTH NO. **FILED MAR 19 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2298**

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis, Mo</b> |  | c. LENGTH OF STAY (in this place)   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Barnes Hospital</b>                                       |  | e. STREET ADDRESS (If rural, give location)<br><b>620 E Main St</b>                   |  |

|   |                                  |  |   |  |   |
|---|----------------------------------|--|---|--|---|
| 3. NAME OF DECEASED<br>(Type or Print)  |                                  |  | 4. DATE OF DEATH  |  |   |
| a. (First)<br><b>Emma</b>   | b. (Middle)<br><b>NMN</b>        | c. (Last)<br><b>Pyle</b>   | (Month)<br><b>3</b>   | (Day)<br><b>10</b>                           | (Year)<br><b>54</b>                       |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>12-17-1900</b>                                 | 9. AGE (In years last birthday)<br><b>53</b> | IF UNDER 1 YEAR<br>Months<br>Days         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                     | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Illinois</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b> |

|  |  |   |
|--|--|---|
| 13a. FATHER'S NAME<br><b>Joseph Mcadoo</b>   | 13b. MOTHER'S MAIDEN NAME<br><b>Mary e Moore</b> | 14. NAME OF HUSBAND OR WIFE<br><b>James H Pyle-Taylorville</b>                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.                          | 17. INFORMANT'S SIGNATURE OR NAME<br><b>James H Pyle Taylorville Illinois</b> |
|  |  | ADDRESS<br><b>Illinois</b>  |

|  |   |  |   |
|--|---|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>four weeks</b> |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Ruptured intra-cranial aneurysm</b>   |  |   |
|  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>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?<br>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) (m.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br><b>452x</b>   |

22. I hereby certify that I attended the deceased from **Mar. 4, 1954**, to **Mar. 10, 1954**, that I last saw the deceased alive on **Mar. 10, 1954**, and that death occurred at **7:15A m.**, from the causes and on the date stated above.

|   |                                   |  |                                    |
|---|-----------------------------------|--|------------------------------------|
| 23a. SIGNATURE<br><b>C. J. Vermillion, M.D.</b> | (Degree or title)<br><b>M. D.</b> | 23b. ADDRESS<br><b>Barnes Hospital</b> | 23c. DATE SIGNED<br><b>3/10/54</b> |
|---|-----------------------------------|--|------------------------------------|

|   |                               |   |  |
|---|-------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 24b. DATE<br><b>3-11-1954</b> | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Masonic-OddFellows</b> | 24d. LOCATION (City, town, or county) (State)<br><b>Benton Ill</b> |
|---|-------------------------------|---|--|

|  |   |  |                                   |
|--|---|--|-----------------------------------|
| DATE REC'D BY LOCAL REG.<br><b>MAR 12 1954</b> | REGISTRAR'S SIGNATURE<br><b>J. Carl Smith</b> | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Woolly &amp; Hoover</b> | ADDRESS<br><b>Taylorville Ill</b> |
|--|---|--|-----------------------------------|

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

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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.....  
Signature of Student Embalmer

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.