

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

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

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** c. LENGTH OF STAY (in this place) **Life**
c. CITY OR TOWN **St. Louis** d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION: **Homer G. Phillips Hosp.** e. STREET ADDRESS (If rural, give location) **21 2935 Delmar Blvd. 2270**

3. NAME OF DECEASED a. (First) **GREGORY** b. (Middle) _____ c. (Last) **KYLES** 4. DATE OF DEATH (Month) (Day) (Year) **Oct. 27, 1954**

5. SEX **Male** 6. COLOR OR RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **single** 8. DATE OF BIRTH **Jan. 21, 1952** 9. AGE (In years last birthday) **2** 9. AGE (In years last birthday) **2** 10. MONTHS **9** 10. MONTHS **9** 10. DAYS **7** 10. HOURS **7** 10. MIN. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **none** 10b. KIND OF BUSINESS OR INDUSTRY **none** 11. BIRTHPLACE (City and State or Foreign Country) **St. Louis, Missouri** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Tom Davis Kyles** 13b. MOTHER'S MAIDEN NAME **Mary Alice Mickens** 14. NAME OF HUSBAND OR WIFE **none**

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 **Mary Kyles** ADDRESS **2735 Delmar Blvd.**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____
ANTECEDENT CAUSES **Meningococic Meningitis**
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.
19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR **0570**

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE **Gabriel Taylor Corcoran** (Degree or title) _____ 23b. ADDRESS **1300 Clark** 23c. DATE SIGNED **10-29-54**

24a. BURIAL, CREMATION, REMOVAL (Specify) **removal** 24b. DATE **11/26/1954** 24c. NAME OF CEMETERY OR CREMATORY **Greenwood Cemetery** 24d. LOCATION (City, town, or county) (State) **St. Louis County, Mo.**

DATE REC'D BY LOCAL REG. **OCT 29 1954** REGISTRAR'S SIGNATURE **J. Earl Smith, MD** 25. FUNERAL DIRECTOR'S SIGNATURE **Charles J. Gates** ADDRESS **4107 Finney Avenue**

WRITE PLAINLY—USING UNFADING 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.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 182

P. O. Address... 4107 Finney

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.