

FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25695**
Registrar's No. **55-74**

BIRTH NO. _____ REG. DIST. NO. **93** PRIMARY REG. DIST. NO. **4153**

1. PLACE OF DEATH a. COUNTY Dade		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Dade	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lockwood		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Greenfield	
c. LENGTH OF STAY (in this place) 11 weeks		d. STREET ADDRESS (If rural, give location) N. Main St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Clyde b. (Middle) Oscar c. (Last) Pyle			4. DATE OF DEATH (Month) (Day) (Year) Aug 28, 1955		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Jan. 15, 1879		9. AGE (In years last birthday) 77		10. MONTHS 7 YEARS 7 DAYS 7 HOURS 7 MINS. 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and State or Foreign Country) Cedar Co., Missouri	
12. CITIZENRY OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME William Pyle		13b. MOTHER'S MAIDEN NAME Emily Alder	
13c. NAME OF HUSBAND OR WIFE Mae Pyle		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 Mr. Kenneth Pyle		ADDRESS Stockton, Mo.			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Cerebral Hemorrhage		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 months	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		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 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) (Min.)		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 **June 4th, 1955**, to **Aug 28th, 1955**, that I last saw the deceased alive on **8-27**, 1955, and that death occurred at **9:15 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Max Heilbrunn M.D.		(Degree or title)		23b. ADDRESS Lockwood, Mo.	
23c. DATE SIGNED 8-28-55		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 30, 1955	
24c. NAME OF CEMETERY OR CREMATORY Greenfield Cem.		24d. LOCATION (City, town, or county) (State) Greenfield, Mo.			

DATE REC'D BY LOCAL REG. 8-28-55		REGISTRAR'S SIGNATURE J. C. Canada		FUNERAL DIRECTOR'S SIGNATURE J. C. Canada	
				ADDRESS Greenfield, Mo.	

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

290

0290

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

J. C. Canada

Licensed Embalmer No.

4196

P. O. Address

Greenfield, 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.