

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20428
STATE FILE NUMBER

FILED JUL 8 1957

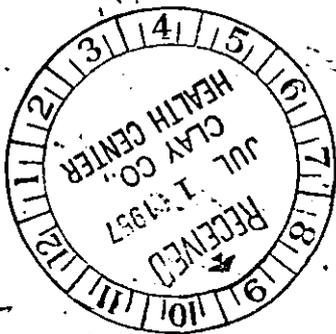
Registration District No. 72 Primary Registration District No. 5289 Registrar's No. 62

1. PLACE OF DEATH a. COUNTY CLAY				2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission) a. STATE MO b. COUNTY Clay			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Gallitan		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN Bladestone Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1/2 mile west of home			Length of stay in lb 1 yr.	d. STREET ADDRESS (If outside, give location) 121 W 66th Terr			Resid On Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Shirley Alice Kyle			First Shirley	Middle Alice	Last Kyle	4. DATE OF DEATH Month 6 - Day 25 - Year 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept 14-46	9. AGE (In years last birthday) 10	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
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. BIRTH PLACE (City and state or country) K.C. Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert J Kyle				14. MOTHER'S MAIDEN NAME Julia A Kristop			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Robert J Kyle of the home			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II, of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE D.S. Tate M.D.			(Degree or title)			22b. ADDRESS North Kansas City, Mo.	22c. DATE SIGNED 5/28/57
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 6-29-57	23c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem		23d. LOCATION (City, town, or county) Kansas City, Kas.		(State)	
24. FUNERAL DIRECTOR D.W. Newcomer			ADDRESS No. 16 P. Mo	25. DATE RECD. BY LOCAL REG. 6-29-57	26. REGISTRAR'S SIGNATURE Marguerite Judgens		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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.....
John H. Kalsbeck

Licensed Embalmer No. 49

P. O. Address No. Kansas

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.