

Health,
& Welfare
Public
Service

FILED NOV 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
10546

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

S. 300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4533 Clayton Ave.</u>		d. STREET ADDRESS (If outside, give location) <u>4533 Clayton Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>LUCINDA</u> Middle Last <u>PYLES</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sep. 12, 1860</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <u>97</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	10c. IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>Edwardsport, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unknown Cook</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown Phillippi</u>	
14. NAME OF HUSBAND OR WIFE <u>Late Richard Pyles</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year (date) of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Eula Johnson</u> Address <u>117 E. Fremont-Elmhurst, Ill.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Solar Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>490x</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebrovascular accident</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input 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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input 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. attended the deceased from <u>Dr. MacFarland</u> <u>1954</u> to <u>November 5, 1957</u> and last saw her alive on <u>November 4, 1957</u> Death occurred at <u>10:58 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>James A. Hutchinson, M.D.</u>	
22b. ADDRESS <u>114 W. Taylor St. Louis 8 Mo.</u>		22c. DATE SIGNED <u>11/6/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal (Mtr)</u>		23b. DATE <u>11-8-57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Piedmont, Mo.</u>	
24. FUNERAL DIRECTOR <u>Kriegshauser</u> ADDRESS <u>4228 S. Kingshighway</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 6 57</u>	
26. REGISTRAR'S SIGNATURE <u>Earl Smith Mo</u> <u>2983</u>			

(Licensed Embalmer's Statement on Reverse Side)

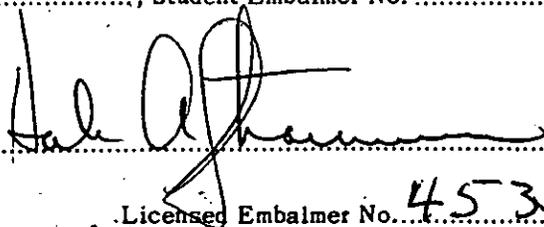
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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. 4533
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.