

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027273

FILED VS AUG 3 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's **B-6643** STATE FILE NUMBER

DED

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b | c. CITY OR TOWN Clayton Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 320 Tanglewood Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM TARYLE | | | 4. DATE OF DEATH Month Day Year July 14, 1959 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11/23/05 | 9. AGE (last birthday) 53 | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Executive | | 10b. KIND OF BUSINESS OR INDUSTRY Wholesale Produce | 11. BIRTHPLACE (City and state or country) New York | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |

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| 13a. FATHER'S NAME Morris Taryle | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Rosemarie Fine Taryle |
| 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. Unk. | 17. INFORMANT Address Mrs. W. Taryle-320 Tanglewood |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) cachexia | | 7 mo |
| DUE TO (b) carcinoma of colon | | |
| DUE TO (c) carcinoma of colon | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <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. I attended the deceased from **October 1958** to **last day** and last saw her alive on **July 14 - 1959**
 Death occurred at **10:30** **P** m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE G. E. Greenfield (degree or title) M.D. | 22b. ADDRESS 4500 Olive | 22c. DATE SIGNED 7/15/59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 7/16/59 | 23c. NAME OF CEMETERY OR CREMATORY B'nai Amoona Cemetery |
| 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo. | | |

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| 24. FUNERAL DIRECTOR ADDRESS Herman Rindskopf, Inc. 5216 Delmar | 25. DATE RECD. BY LOCAL REG. JUL 16 '59 | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mgb

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John Ketter
Licensed Embalmer No. 3888

P. O. Address _____

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