

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002660

FILED VS FEB 1 1960

STATE FILE NUMBER

Registration District No. 201 Primary Registration District No. 9048 Registrar's No. 23

DED

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Nodaway</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maryville</u>		Length of stay in 1b <u>2 das</u>		c. CITY OR TOWN <u>Graham</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Francis Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>EMERY</u> Last <u>LYLE</u>				4. DATE OF DEATH Month <u>1</u> Day <u>23</u> Year <u>1960</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>cau</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12, 10, 1883</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Graham, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James Lyle</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Gillis</u>			14. NAME OF HUSBAND OR WIFE <u>Mrs Mabel Lyle</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Mrs Mabel Lyle, Graham, Mo.</u>			
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) <u>abremia</u>							<u>24 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebrovascular Hemorrhage.</u>							<u>5 days</u>	
DUE TO (c) _____								
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		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ 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 <u>Jan 19, 1960</u> to <u>Jan 23, 1960</u> and last saw him alive on <u>Jan 23, 1960</u> . Death occurred at <u>6:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>R. E. Dunbar M.D.</u>				22b. ADDRESS <u>Maryville, Mo.</u>			22c. DATE SIGNED <u>Jan 25, 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>1/26/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Graham Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Graham, Mo.</u>			
24. FUNERAL DIRECTOR <u>W. H. Johnson Maryville Mo</u>				25. DATE RECD. BY LOCAL REG. <u>25 60</u>		26. REGISTRAR'S SIGNATURE <u>Bess Holt</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 G. M. Atkinson

Licensed Embalmer No. 2279

P. O. Address Weymouth

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.