JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-028539
STATE FILE NUMBER

FILED VS AUG 10 1960 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7352

NDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis Mo.
Length of stay in 1b
c. CITY OR TOWN Jennings
Inside Limits Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Lukes Hospital
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 1916 McLaran AVE
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Frank Middle Robert Last Kyle
4. DATE OF DEATH Month 7- Day 21 Year 1960

5. SEX Male
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 8-20-1912
9. AGE (last birthday) 47
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) Salesman
10b. KIND OF BUSINESS OR INDUSTRY Selfemployed
11. BIRTHPLACE (City and state or country) St Louis, Mo.
12. CITIZEN OF WHAT COUNTRY Yes

13a. FATHER'S NAME Andrew Kyle
13b. MOTHER'S MAIDEN NAME Mary A Godfrey
14. NAME OF HUSBAND OR WIFE Florene Kyle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Florene Kyle Address 1916 McLaran ave.

MEDICAL CERTIFICATION

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)	Cerebro Vascular Accident - in pons	Terminal
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Hypertension Mod. severe	2 yrs
DUE TO (c)	Congestive Heart Failure	2 mnt

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
443 X

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 June 29 60 to July 21 and last saw ~~her~~ him alive on July 21 1960
Death occurred at 8 a.m. July 21 1960 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE THK Robert (Degree or title) M D
22b. ADDRESS 110 S. Central Clayton
22c. DATE SIGNED July 22 K

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 7/25/60
23c. NAME OF CEMETERY OR CREMATORY Lake Wood Park
23d. LOCATION (City, town, or county) St Louis, Mo (State)

24. FUNERAL DIRECTOR JOHN STYGAR & SON ADDRESS 5541 Riverview
25. DATE RECD. BY LOCAL REG. JUL 23 1960
26. REGISTRAR'S SIGNATURE Hoard Smith, M.D.
M. J. B.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed J M Pistu

Signature of Student Embalmer

Licensed Embalmer No. 3980

P. O. Address St. Louis, Mo.

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