

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 28 1960

=60-037829

STATE FILE NUMBER

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 358

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u>		c. CITY OR TOWN <u>New Bloomfield</u>	
Length of stay in 1b <u>5 Weeks</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hosp</u>		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>Marion</u> Middle <u>Cole</u> Last <u>Kyger</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1960</u>		
5. SEX <u>Male</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>2-10-1892</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR IF UNDER 24 HR
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>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Callaway Co Mo</u>	
10c. CITIZEN OF WHAT COUNTRY <u>USA.</u>		13a. FATHER'S NAME <u>Lewis Kyger</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Craig</u>	
13c. NAME OF HUSBAND OR WIFE <u>Eula Kyger</u>		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. <u>487-40-9950</u>	
17. INFORMANT <u>Gilbert Kyger</u>		Address <u>New Bloomfield</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>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
DUE TO (b) <u>arteriosclerosis</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) <u>fracture left femur</u>		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 checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Fell at home fracturing left femur</u>
20c. TIME OF INJURY Hour <u>12:50 A.M.</u> Month, Day, Year <u>9-18-60</u>		

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.) <u>in home</u>	20f. CITY, TOWN, OR LOCATION <u>New Bloomfield, Callaway Mo</u>	COUNTY <u>Callaway</u>	STATE <u>Mo</u>
21. I attended the deceased from <u>9-18-60</u> to <u>Oct 23</u> and last saw him alive on <u>Oct 23</u>		Death occurred at <u>12:50 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (D, M, or title) <u>Dean C. Dwyler M.D.</u>	22b. ADDRESS <u>Jefferson City</u>	22c. DATE SIGNED <u>10-24-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 25-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Cemetery</u>
23d. LOCATION (City, town, or county) <u>West New Bloomfield Mo</u>	24. FUNERAL DIRECTOR <u>Claypool Sec. New Bloomfield</u>	25. DATE RECD. BY LOCAL REG. <u>24 October 1960</u>
26. REGISTRAR'S SIGNATURE <u>R.P. Davis M.D. - Richter, Mo</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 LeRoy Claypool

Licensed Embalmer No. 4412

P. O. Address New Bloomfield

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.