

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-038904
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. _____

318 Primary Registration District No. _____

1003 Registrar's No. _____

10383

AMENDED

FILED NOV 15 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in lb	c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4588 No. MARKET		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FERDIE Middle H. Last LYLES			4. DATE OF DEATH Month NOVEMBER Day 5 Year 1961		
5. SEX MALE	6. COLOR OR RACE COLORED	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-22-1900	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) ARKANSAS		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME GEORGE LYLES		13b. MOTHER'S MAIDEN NAME MARTHA*****		14. NAME OF HUSBAND OR WIFE JETTIE LYLES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO.		17. INFORMANT JETTIE LYLES, 4588 No. MARKET Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE					INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE					8 YEARS
DUE TO (c) 4200					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHRONIC PYELONEPHRITIS				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 checked="" 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 _____ s.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 MARCH 6, 1960 to NOV. 5, 1961 and last saw her/him alive on NOV. 5, 1961 Death occurred at 6:15 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>C. D. Vermillion, M.D.</i> (Degree or title)			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 11/6/61.
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 10-10-61	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK		23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MO.	
24. FUNERAL DIRECTOR THOMAS JACKSON		ADDRESS 2741 DICKSON ST.		25. DATE RECD. BY LOCAL REG. NOV 8 1961	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

ITEM NO. SHOULD READ

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leroy W. Jannister

Licensed Embalmer No. 4523

P. O. Address 4251 Waco

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.