

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

10297

-61-039415
STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10297

FILED NOV 10 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS MO</u>		Length of stay in 1b <u>8 DAYS</u>	c. CITY OR TOWN <u>ST. LOUIS</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. ANTHONY HOSPITAL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>9437 McKENZIE</u>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>NYLIE</u>			4. DATE OF DEATH Month <u>11</u> - Day <u>4</u> - Year <u>1961</u>
5. SEX <u>FEMALE</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>8-25-1973</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	9. AGE (last birthday) <u>88</u>
13a. FATHER'S NAME <u>WILLIAM SIMPSON</u>		13b. MOTHER'S MAIDEN NAME <u>MIGNERVA J. MERRITT</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A</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>NONE</u>	14. NAME OF HUSBAND OR WIFE <u>JOHN C NYLIE</u>
17. INFORMANT <u>EDITH PYBAS</u>		Address <u>9437 MCKENZIE</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>Oct. 27, 1961</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____			331X
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>Solar pneumonia; arteriosclerosis cardio vascular</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 <u>27 Oct. 1961</u> to <u>4 Nov. 1961</u> and last saw her alive on <u>4 Nov. 1961</u> Death occurred at <u>3:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert L. Nye, M.D.</u>		22b. ADDRESS <u>3201 Arsenal St. St. Louis Mo.</u>	22c. DATE SIGNED <u>6 Nov. 1961</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>11-7-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAKELWOOD PARK</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY MO</u>
24. FUNERAL DIRECTOR <u>HOWARD H. MICHEL</u>		ADDRESS <u>5930 SOUTH WEST</u>	25. DATE RECD. BY LOCAL REG. <u>NOV 6 1961</u>
		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>	

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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 Robert J. Gar Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 27 Mo

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.