ISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-043175
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3185

FILED NOV 30 1961

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton — Length of stay in 1b DOA
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Co. Hosp.. — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Kirkwood — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 934 Evans Ave. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First MARGARET Middle E. Last KYBURZ

4. DATE OF DEATH Month Nov. Day 10, Year 1961

5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 9-1-1892
9. AGE (last birthday) 69
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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Charles Queenan
13b. MOTHER'S MAIDEN NAME Unk. McGarren
14. NAME OF HUSBAND OR WIFE Barney Kyburz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

17. INFORMANT Margaret M. Froesel Address 934 Evans Ave. Kirkwood, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Unrecognizable disease — INTERVAL BETWEEN ONSET AND DEATH Unk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ 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. ☐ 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 ____ to ____ and last saw her/him alive on ____
Death occurred at 4:26 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) Coroner
22b. ADDRESS Clayton, Mo.
22c. DATE SIGNED 11/15/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 11-13-1961
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.
23d. LOCATION (City, town, or county) (State) Festus, Mo.

24. FUNERAL DIRECTOR ADDRESS Pfitzinger Mort-Kirkwood 22, Mo.
25. DATE RECD. BY LOCAL REG. 11-13-61
26. REGISTRAR'S SIGNATURE John B. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED — INSTEAD OF — DOCUMENT — 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_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.