

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-018479

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 87 Primary Registration District No. 4565 Registrar's No. 32

FILED JUN 13 1962

VS 300 Rev. 4/59

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2363

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN CRAWFORD</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SULLIVAN</u>		c. CITY OR TOWN <u>Sullivan</u>	
Length of stay in 1b <u>12 Years</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>SULLIVAN COMMUNITY HOSPITAL</u>		d. STREET ADDRESS (if outside, give location) <u>104 Blair</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Elizabeth</u> Last <u>Dyle</u>		4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-1915</u>
9. AGE (last birthday) <u>46</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </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	11. BIRTHPLACE (City and state or country) <u>Route 1, Sullivan, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Jacob Leslie Linthicum</u>	
13b. MOTHER'S MAIDEN NAME <u>Katy Elizabeth Adams</u>		14. NAME OF HUSBAND OR WIFE <u>Harry Dyle</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> </u>	
17. INFORMANT <u>Jacob Leslie Linthicum, Father</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pyelonephritis</u> DUE TO (b) <u>Chronic Cystitis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Paraplegia due to Spinal Cord Surgery (Spinal Cord Tumor-1946)</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 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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>			
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 <u> </u>	STATE <u> </u>
21. I attended the deceased from <u>1949</u> , to <u>1962</u> and last saw her alive on <u>May 24, 1962</u> Death occurred at <u>9:00 AM.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John J. de la Torre</u> (Degree or title)		22b. ADDRESS <u>26 West Main, Sullivan, Missouri</u>	
22c. DATE SIGNED <u>5-28-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 29, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crow</u>	
23d. LOCATION (City, town, or county) <u>Franklin County, Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Sullivan Memorial Funeral Home</u> ADDRESS <u> </u>		25. DATE RECD. BY LOCAL REG. <u>May 29, 1962</u>	
		26. REGISTRAR'S SIGNATURE <u>William Cowan</u>	

USE BLACK INK OR TYPEWRITER RIBBON

JUN 26 1962

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 F. M. Lenox

Licensed Embalmer No. 3601

P. O. Address St. Clair, 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.