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FILED MAY 16 1949

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 13719  
1700

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1407 Park  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 47 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1407 Park  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28  
year 1941 hour 1:00 minute 5 a M.  
21. I hereby certify that I attended the deceased from Jan. 10, 1941  
19\_\_\_\_, to April 28, 1941;  
that I last saw h. H alive on April 28, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Terminal Pneumonia  
Due to Chronic Myocarditis  
Due to 93 F  
Other conditions: Perniciou anemia  
(Include pregnancy within 3 months of death)

Duration  
24 hrs.  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Grace Dexter Pyle

3. (b) If veteran, name war no. 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ralph M. Pyle 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased Dec 12 - 1893  
(Month) (Day) (Year)

8. AGE: Years 47 Months 4 Days 16 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Ralph Marrs

13. Birthplace R. P. Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Ida Skinner

15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Ralph M. Pyle

(b) Address 1407 Park

17. (a) Burial (b) Date thereof April 29, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Mrs. C. R. Fenter

(b) Address 918-B Brooklyn

19. (a) Apr 29 41 (b) M. M. Crown  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify): no  
(b) Date of occurrence no  
(c) Where did injury occur? no  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (c) Means of injury no

23. Signature Edred E. Welch (M. D. or other) M.D.  
Address 706 Prof Bldg. Date signed 7/28/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

ANALYST OF DEPARTMENT OF HEALTH & HUMAN SERVICES  
1885

**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

....., Registered Apprentice No. ....

working under my personal supervision.

Signed *Donald C. Browning*

Licensed Embalmer No. 2784

P. O. Address *H.C. 2nd*

**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 this body is not embalmed, fact should be so stated above.**

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STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 1700

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1407 Park  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... years, months or days)

3. (a) PRINT FULL NAME Grace Denton Pyle

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
47 4 16 hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 4/29/41 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month April day 28<sup>th</sup>  
year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw him..... alive on....., 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death terminal pneumonia (Bronchial)

Due to Chronic Myocarditis

Due to..... 93 D

Other conditions..... (Include pregnancy within 3 months of death)

Major findings:

Of operations.....

Of autopsy.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERM. NENT RES. U.S. PAT. OFF. 1937

S-13719