

No. 2  
5-43  
17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11182 ✓

FILED MAR 27 1944

State File No. \_\_\_\_\_

Registration District No. 176

Primary Registration District No. 5568

Registrar's No. 36

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence, E. Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 1602 Sterling Blue Twp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days) 21 years

In this community \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Independence Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. 1602 Sterling Blue Twp.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME RUTH MARGARET. PYLE

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 29, 1922  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 1 year 1944 hour 5 minute 30 a. M.

21. I hereby certify that I attended the deceased from 1938, 19\_\_\_\_, to Feb 1, 1944; that I last saw her alive on April, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary T. B. chr.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

8. AGE: Years 21 Months 8 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name Ernest S. Pyle

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

14. Maiden name Elaine Musterson

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

16. (a) Informant Miss Elaine Pyle

(b) Address 1602 Sterling

17. (a) Burial (b) Date thereof Feb. 5-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wood lawn

18. (a) Signature of funeral director George C. Carson

(b) Address Independence, Mo.

19. (a) 2-5-1944 (b) James W. Ross  
(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) \_\_\_\_\_

(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 George Vetter (M. D. or other) \_\_\_\_\_

Address 11037 Winner Rd. Independence Date signed 2-5-44

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

1163

**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..... *Dean Rivers*

Licensed Embalmer No. *4280*

P. O. Address *Indep. 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 this body is not embalmed, fact should be so stated above.**

Registration District No. 146

Primary Registration District No. 5568

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Ruth M. Pyle

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased..... May 29  
(Month) (Day) (Year)

8. AGE: Years 21 Months 8 Days..... If less than one day..... min.

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

10. Usual occupation at home

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)  
(Burial, cremation, or removal)

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

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

(b) Address.....

19. (a)..... (b) James W. Ross  
(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) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1 year 1944 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....  
that I last saw him..... alive on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

Due to.....

Due to.....

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

Major findings: Of operations.....

Of autopsy.....

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.....

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

SUPPLEMENTARY

11182