MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

31629

File No.

Registered No. 9281

1. PLACE OF DEATH

County

Township

City St Louis (No. 1025 Armstrong St. Ward)

Registration District No. 791

Primary Registration District No. 1003

2. FULL NAME John Doolin

(a) Residence. No. 1025 Armstrong St., 22 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Husband of Lola Doolin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 4 1884.

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
45	9	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Illinois.

PARENTS

10. NAME OF FATHER: Mike Doolin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Irland

12. MAIDEN NAME OF MOTHER: Mary Elder

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Illinois

14. INFORMANT: Mrs Lola Doolin
(Address) 1025 Armstrong

15. FILED 19 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 25. 1930.

17. No Physician in attendance
I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 8 30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

93 C (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 90 B (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) John [signature], M.D.

9/26, 1930 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Litchfield Ill.

DATE OF BURIAL: 9/27 1930

20. UNDERTAKER: McLaughlin

ADDRESS: 1631 Missouri

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.