

REC'D MAR 13 1939

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

4956
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **De Paul Hospital** Registered No. **1649**
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Mary T. Doyle**

(a) Residence, No. **5119 Minerva Ave.** St. **6** (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **James J. Doyle**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 2, 1852**

7. AGE YEARS **86** MONTHS **9** DAYS **16** If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **House work**
9. Industry or business in which work was done, as saw mill, bank, etc. **Home**
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo.**

13. NAME **Wm. F. Kinsella**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

15. MAIDEN NAME **Anastatia Connelly**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

17. INFORMANT (ADDRESS) **Mrs. William F Mc Henry 5119 Minerva Ave.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **Feb. 21, 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Cullen & Kelly 1416 N. Taylor Ave.**

20. FILED **FEB 20 1939** Local Registrar **J. B. Bader**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **2/18/39**

22. I HEREBY CERTIFY, That I attended deceased from **1/23/39** to **2/18/39**
I last saw her alive on **2/18/39** Death is said to have occurred on the date stated above, at **5:30 p.m.**

The principal cause of death and related causes of importance were as follows:
Acute Cardiac Failure
Chr Myocarditis
Chr Nephritis
Ac Bronchitis

Other contributory causes of importance:
Fracture of Femur at Hip 1/23/39
Neurotic Pressure sore 2/1/39
Arteriosclerosis

Name of operation Date of operation
What test confirmed diagnosis? **X-ray** Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or poisoning **Fall** Date of injury **1/23/39**
Where did injury occur? **5119 Minerva at Home** Specify city or town, county, and State
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **Fall at Home 5119 Minerva**
Nature of injury **Fracture of Femur at Hip**

24. Was disease or injury in any way related to occupation of deceased? **NO**
If so, specify **George S. Thebar** M. D.
(Signed) **George S. Thebar** (address) **1006 So Jefferson**

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.

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 *Mark Tiernon*

Registered Apprentice No. *174*, working under my personal supervision.

Signed *Clement McManuf*

Licensed Embalmer No. *3732*

P. O. Address *St. Louis*

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, above space should be left blank.