

S. D. 11-10-39
7. 5. 11-39
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FILED JUN 6 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17852

State File No. _____
Registrar's No. 9

Registration District No. 74

Primary Registration District No. 5113

1. PLACE OF DEATH:
(a) County: Boone
(b) City or town: Hallsville Rural Route
(c) Name of hospital or institution: No
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No
In this community 52 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Boone
(c) City or town: Hallsville Rural
(d) Street No.: Rural
(e) If foreign born, how long in U. S. A.? No years.

3. (a) PRINT FULL NAME: GEORGE T DOYLE

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 24
year 1940 hour 3 minutes P M.

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

21. I hereby certify that I attended the deceased from 5 May 24, 1940 to May 21-40, 1940; that I last saw him alive on May 21-40, 1940; and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife: Mary ELIZABETH Doyle 6. (c) Age of husband or wife if alive: Dead years
7. Birth date of deceased: Nov. 1, 1884
(Month) (Day) (Year)

Immediate cause of death: Cerebral Hemorrhage Duration 3 days

8. AGE: Years 85 Months 5 Days 23 If less than one day _____ hr. _____ min.

Due to: General Arteriosclerosis

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

Due to: _____

10. Usual occupation: FARMER

Other conditions (Include pregnancy within 3 months of death): gfw

11. Industry or business: "

PHYSICIAN _____

MOTHER FATHER { 12. Name: William D Doyle
13. Birthplace: Indiana
14. Maiden name: Catherine Daugherty
15. Birthplace: Ohio

Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

16. (a) Informant: J. C. Doyle
(b) Address: Palmsville Mo. 830
17. (a) Burial (b) Date thereof: May 26 1940
(c) Place: burial or cremation: MT ZION CRM

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

18. (a) Signature of funeral director: A. D. Wilson
(b) Address: _____
19. (a) 5-28-40 (b) Max F. [Signature]
(Date received local registrar) (Registrar's signature)

23. Signature: Stephen D. [Signature] (M. D. or other) _____
Address: Columbus Date signed _____

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

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 Lyman H. Sprinkle

Licensed Embalmer No. 4013

P. O. Address Columbia, 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, above space should be left blank.