

Registration District No. 399

Primary Registration District No. 1002

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

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:
In City Ambulance
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community 20 years 3 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Frank Doyle
 3. (b) If veteran, name war None
 3. (c) Social Security No. None

4. Sex Male 5. Color or race Negro
 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 April 6, 1920
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>21</u>	<u>8</u>	<u>6</u>	_____ hr. _____ min.

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

10. Usual occupation City Employee

11. Industry or business _____

MOTHER FATHER { 12. Name Silas Doyle
 13. Birthplace Greenville Miss.
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Angeline Miles
 15. Birthplace Linden Texas
(City, town, or county) (State or foreign country)

16. (a) Informant Angeline Doyle
 (b) Address 1321 Jackson

17. (a) burial (b) Date thereof 12/18/41
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Westlawn Cemetery

18. (a) Signature of funeral director Starkins Bess
 (b) Address 1729 Lydia

19. (a) Nov 17 1941 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

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. 1723 Woodland
(If rural, give location)
 (e) - If foreign born, how long in U. S. A.? No years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month December day 12th
 year 1941 hour 9 minute 25 P.M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her on _____, 19____; and that he/she died on the date and hour stated above.

Immediate cause of death: External fatal hemorrhage
stab wound of the neck

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

Major findings: _____
 Of operations: _____
 Of autopsy: yes

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) Homicide
 (b) Date of occurrence 12-18-41
 (c) Where did injury occur? R.C. (City or town) (County) Mo

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work _____ (Specify type of place)
 (Specify type of injury)

23. Signature Lyons (M. D. or other) _____
 Address R.C. Mo Date signed _____

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

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 _____

Licensed Embalmer No. 2710

P. O. Address Kansas City 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.