

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 586

FILED JUN 8 1944 12
Registration District No. _____

Primary Registration District No. 1000

0. 2
3-43
7-39
K37823

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

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Mercy Hospital 17
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 hours
(Specify whether
 In this community 7 hours
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan 11
 (c) City or town St. Joseph 1
(If outside city or town limits, write "RURAL")
 (d) Street No. 1309 Grand Avenue 7
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country D

3. (a) PRINT FULL NAME Jeanette Marie Doyle
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 3rd.
 year 1944 hour _____ minute _____ M. _____

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

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. e.f. alive on _____, 19____;
 and that death occurred on the date and hour stated above.

7. Birth date of deceased June 3 1944
(Month) (Day) (Year)
 8. AGE: Years Months Days If less than one day
0 0 0 7 hr. _____ min.

Immediate cause of death _____
Premature Birth
 Due to _____
 Due to _____

9. Birthplace St. Joseph Missouri A
(City, town, or county) (State or foreign country)
 10. Usual occupation None
 11. Industry or business _____

Other conditions (Include pregnancy within 3 months of death) _____
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 Major findings: Of operations _____
 Of autopsy _____

MOTHER FATHER
 12. Name James C. Doyle
 13. Birthplace Mt. Sterling Kentucky 1
(City, town, or county) (State or foreign country)
 14. Maiden name Inez B. Frazier
 15. Birthplace Hope Kentucky 1
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant James C. Doyle
 (b) Address 1309 Grand Avenue, St. Joseph, Mo.
 17. (a) Burial (b) Date thereof 6/5/1944
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Memorial Park Cemetery

While at work? _____ (Specify type of place) _____ (c) Means of injury _____
 23. Signature Will D. Brown (M. D. or other) D.O.
 Address 222 Logan B. Date signed 6/5/44

18. (a) Signature of funeral director Walter Meinhoff
 (b) Address 13th & Faraon St., St. Joseph, Mo.
 19. (a) 6/5/44 (b) Nelson L. Coker
(Date received local registrar) (Registrar's signature)

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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 *Albert C. Harrington*

Licensed Embalmer No. 3258 Missouri

P. O. Address St. Joseph, Missouri.

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.