

FILED JAN 25 1945
378

1003

State File No.

Registrar's No.

461

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: De Paul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME William J. Doyle

3. (b) If veteran, name war _____ 3. (c) Social Security No. 361-09-8227

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sybilline Tulley Doyle 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased December 25 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>0</u>	<u>20</u>	hr. _____ min.

9. Birthplace E. St. Louis Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Live Stock Inspector

11. Industry or business Live Stock

12. Name John Doyle

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Cooney

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Sybilline Doyle

(b) Address 18 Juanita, Belleville, Ill.

17. (a) Burial (b) Date thereof 1/17/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot-Carroll

(b) Address 4600 Natural Bridge Ave.

19. (a) JAN 16 1945 (b) J. Medel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County 999
(c) City or town Belleville 11
(If outside city or town limits, write "RURAL") N.B.
(d) Street No. 18 Juanita Place
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 15
year 1945 hour 9 minute A M.

21. I hereby certify that I attended the deceased from Jan 1 1945 to Jan 15 1945
that I last saw him alive on Jan 14 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac vascular renal disease with hypertension Duration 2 yrs

Due to Arteriosclerosis

Due to Cause unknown

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

Major findings: _____
Of operations: _____

Of autopsy: _____

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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. Medel (M. D. or other)

Address 117 N. Grand Date signed 1/17/45

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

MOTHER FATHER

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address.....

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.