V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 5 1945

Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1082

State File No. 8558

Registrar's No. 1339

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

18
3
8

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: ~~[illegible]~~ 7326 Cleveland /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 53 Yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 7326 Cleveland 8
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME James Doyle

3. (b) If veteran, name war No

3. (c) Social Security No. no

4. Sex Male 0

5. Color or race W

6. (a) Single, widowed, married, divorced Married /

6. (b) Name of husband or wife Verna Doyle

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased June 25 1891
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
53	8	26	..... hr. ..... min.

9. Birthplace Kansas City (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Depty Sheriff

11. Industry or business .....

FATHER
12. Name James C. Doyle
13. Birthplace ..... (City, town, or county) N.Y. / (State or foreign country)

MOTHER
14. Maiden name Frances C. Hogwood
15. Birthplace Cario Illinois / (City, town, or county) (State or foreign country)

16. (a) Informant Verna Doyle

(b) Address 7326 Cleveland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 24 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cem.

18. (a) Signature of funeral director Mrs CL. Forster

(b) Address 918 Brooklyn

19. (a) 3-23-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 21
year 1945 hour 8 25 minute a M.

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

Immediate cause of death Gun shot Wound of head

Due to .....

Due to 164 C

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....

Of autopsy No History & Inspection

Duration

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) Suicide.

(b) Date of occurrence 3-21-45

(c) Where did injury occur? 7326 Cleveland (City or town) K.C. Jackson (County) Mo. (State)

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

While at work? no (e) Means of injury 12 gage shot gun

23. Signature James C. Walker 3 (M. D. or other) Crown

Address 1424 Prospect Ave 3 Date signed 3-21-45

(Licensed Embalmer's Statement on Reverse Side)

APR 20 1945

APR 1[illegible] 1945

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 C H Wise

Licensed Embalmer No. 2570

P. O. Address K C 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.