

FILED FEB 7 1948

State File No. _____

327

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

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:
St. John & Benton Blvd., 3
 (If not in hospital or institution, write street number or location)
no
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 27 yrs
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson **48**
 (c) City or town Kansas City **3**
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5010 Norledge **8**
 (If rural, give location) **0**
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Barbara Doyle

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

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife William J. Doyle 6. (c) Age of husband or wife if
44 years
 7. Birth date of deceased 3 28 1905
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
40 9 21 _____ hr. _____ min.

9. Birthplace Valentine Nebraska
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER { 12. Name George W. Bowman **9**
 13. Birthplace Unknown (State or foreign country)
 14. Maiden name Stella A. Miller
 15. Birthplace Unknown (State or foreign country)

16. (a) Informant William J. Doyle
 (b) Address 5010 Norledge

17. (a) Burial (b) Date thereof 1/22/46
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director John P. Sheil
 (b) Address Kansas City, Mo.

19. (a) 1-21-46 (b) Stallone Holmes
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 19
 year 1946 hour 11:20 minute 0 M.

21. I hereby certify that I attended the deceased from _____, 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 _____
Fractured skull
Crushed chest & pelvis -
 Due to Auto Trauma

Due to _____

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

Major findings: _____
 Of operations _____
 Of autopsy no
History & Postmortem

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident
 (b) Date of occurrence 1-19-46
 (c) Where did injury occur? 1001 Jackson mo
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
public place

While at work? no (Specify type of place) (e) Means of injury Auto Trauma

23. Signature James Walker (M. D. or other) Walker
 Address 1424 1/2 11th Date signed 1-20-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

NOV 15 1957

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..... *John P. Sheel*

Licensed Embalmer No. *3625*

P. O. Address *M. C. Ho*

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.

Registration District No. 149

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Registrar's No. 327

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:

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

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar 2 1901
(Month) (Day) (Year)

8. AGE: Years 40 Months 9 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 1946 year 1946 hour _____ minute _____ M.

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

Immediate cause of death _____

Fractured Skull Crushed Chest and Pelvis
Due to Auto Trauma

Due to Ambulance hit fixed object

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

Major findings: Of operations _____

Of autopsy 1702-8-27

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 1-19-46

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place

While at work? N.D. (Specify type of place) (e) Means of injury Auto Trauma

23. Signature Dr James C. Walker, Coroner (M. D. or other)

Address 1424 Professional Bldg Date signed 1-20-46

SUPPLEMENTARY

MOTHER FATHER

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

1332