

No. 2
12-45
5-17-39
K47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2421

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **367**

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Infirmiry Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2/26/1940 to
1/12/47 (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Florence Doyle

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

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

7. Birth date of decease Sept. 25, 1884
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan, day 12
year 1947 hour 11 minute AM M.

21. I hereby certify that I attended the deceased from 10/18/45
_____ 19____ to 1/12 1947
that I last saw her alive on 1/12 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Ulceration

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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

8. AGE: Years Months Days If less than one day
62 3 17 hr. _____ min.

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

10. Usual occupation nil

11. Industry or business _____

12. Name Arthur Doyle

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

14. Maiden name Marrietta Powell

15. Birthplace New York
(City, town, or county) (State or foreign county)

16. (a) Informant City Infirmiry Records
(b) Address 5800 Arsenal St.

17. (a) BURIAL (b) Date thereof 1-14-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director M. J. Coughlan
(b) Address 7146 Manchester

19. (a) JAN 13, 1947 (b) J. J. Brudick
(Date received local registrar) (Registrar's signature)

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 John E. Kelly, M. D. (M. D. or other) _____
Address 5600 Arsenal Date signed 1/12/47

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

MOTHER FATHER

107
A-E
AX

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..... *J. W. Wilkinson*
Licensed Embalmer No..... *3575*
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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Feb*

Registrar's No. *367*

Registration District No.

Primary Registration District No.

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:
 (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 Florence 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 5

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

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

8. AGE: Years 62 Months 3 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Nurse

11. Industry or business _____

MOTHER FATHER

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 _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Bredeek
 (Date received local registrar) (Registrar's signature) Feb 17

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 _____ Day _____
 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to _____

Due to _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY 2

2421

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