

No. 2
-1/47
5-17-39

FILED AUG 16 1947
Registration District No. **422**

Primary Registration District No. **1000**

WRITE PLAINLY—USING 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:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Weeks**
(Specify whether
In this community **About 92 Years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **1025 1/2 Ridenbaugh St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country *****

3. (a) PRINT FULL NAME **Bridget Doyle**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **5**
year **1947** hour **12** minute **15 A.M.**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **John**
6. (c) Age of husband or wife if alive ***** years
7. Birth date of deceased **May 15 1855**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **7/21**, 19**47**, to **8/4**, 19**47**, that I last saw him alive on **8/4**, 19**47**, and that death occurred on the date and hour stated above.
Duration **5 days**

8. AGE: Years **92** Months **2** Days **20**
If less than one day hr. min.

Immediate cause of death **Myocardial infarction**
Due to **Thrombus in femoral**
Due to

9. Birthplace **Kansas City, Missouri**
(City, town, or county) (State or foreign country)

Other conditions **Myocardial infarction**
(Include pregnancy within 3 months of death)

10. Usual occupation **Housewife**
11. Industry or business **None**
12. Name **John Burke**
13. Birthplace **Unknown, Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Catherine Lysaght**
15. Birthplace **Unknown, Ireland**
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings: **1867**
Of operations: **18**
Of autopsies:

16. (a) Informant **Miss Mary Burke**
(b) Address **1025 1/2 Ridenbaugh St.**
17. (a) **Burial** (b) Date thereof **Aug. 7, 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **accident 131**
(b) Date of occurrence **7/29/47**
(c) Where did injury occur **St. Joseph, Buchanan Mo.**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Home**
While at work? **no** (Specify type of place)
(e) Means of injury **fall on floor**

18. (a) Signature of funeral director **Thomas W. Jenkins**
(b) Address **1802 Union St., St. Joseph, Mo.**
19. (a) **8-8-47** (b) **T. W. Jenkins**
(Date received local registrar) (Registrar's signature)

23. Signature **Frank J. Jenkins** (M. D.)
Address **620 Branch** Date signed **8/5/47**

St. Joseph, Mo

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

Elmer Thomas

Licensed Embalmer No.

2640

P. O. Address

St. Joseph 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.