

FILED MAY 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19029

BIRTH NO. _____		REG. DIST. NO. <u>324</u>		PRIMARY REG. DIST. NO. <u>3072</u>		Registrar's No. <u>101</u>	
1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall</u>		c. LENGTH OF STAY (in this place) <u>3 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall 0912</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon Memorial Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>610 N. Franklin</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>DANIEL</u>			b. (Middle) _____		c. (Last) <u>DOYLE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May-12-1950</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>February 9, 1879</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>Baldwinsville New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Patrick Doyle</u>			13b. MOTHER'S MAIDEN NAME <u>Ellen Baker</u>		14. NAME OF HUSBAND OR WIFE <u>Edna Helen (Aston) Doyle</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Spain and W.W.I.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Edna Helen Doyle Marshall mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>1902 & 1936</u>		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Left cerebral hemorrhage</u>					
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterial hypertension & sclerosis</u>					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes mellitus</u>					<u>331X</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Marshall Saline mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>May 4</u> , 19 <u>50</u> , to <u>May 12</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>50</u> , and that death occurred at <u>3:20 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>S. P. Wilson M.D.</u>				23b. ADDRESS <u>Marshall mo</u>		23c. DATE SIGNED <u>5-13-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 14, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Marshall mo</u>		
DATE REC'D BY LOCAL REG. <u>May 14-1950</u>		REGISTRAR'S SIGNATURE <u>Sidney J. Gray</u> <u>385</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Harry Hershberger Marshall mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

972
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RECEIVED MAY 22

District Health Officer No. 8,

District File Number _____

Date Filed 5/22/50

8 NOV

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____

Student Embalmer

Signed _____

Joseph R. Mackler

Licensed Embalmer No. 4571

P. O. Address Marshall, 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.