

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33134

State File No. ....

No. 300  
10-48

FILED OCT 24 1951

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BIRTH NO. ....		REG. DIST. NO. <u>116</u>		PRIMARY REG. DIST. NO. <u>3020</u>		Registrar's No. <u>138</u>	
1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Franklin</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Washington</u>		c. LENGTH OF STAY (In this place) <u>12 hrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Clair - Mo</u>		d. STREET ADDRESS (If rural, give location) <u>none - 0360</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) a. (First) <u>William Nelson</u> b. (Middle) <u>Doyle</u> c. (Last) <u>Doyle</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10-14-51</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>6-20-1898</u>		9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>24</u>	IF UNDER 4 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if discontinued) <u>Farmer - Fred Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Stanton - Mo - U</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Herbert Doyle</u>			13b. MOTHER'S MAIDEN NAME <u>Sallie Moss</u>		14. NAME OF HUSBAND OR WIFE <u>DeLa-</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>495-12-8469</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Harold Doyle - St. Clair -</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Chronic Duodenum Ulcer - 7 years -</u>  PRECEDENT CAUSES A. Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Vascular hypertension 7 years -</u>					INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>5410</u>			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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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>9-28</u> , 19 <u>51</u> , to <u>10-14</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>10-13</u> , 19 <u>51</u> , and that death occurred at <u>7:30</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>W. E. Kitchell - M.D.</u> (Degree or title)				23b. ADDRESS <u>St. Clair - Mo</u>		23c. DATE SIGNED <u>10/14/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-16-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cave Spring</u>		24d. LOCATION (City, town, or county) (State) <u>Franklin Co - Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Oct. 15, 1951</u>		REGISTRAR'S SIGNATURE <u>F. P. Sudman</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sherrill Hotel St. Clair Mo</u>			

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

RECEIVED

OCT 21 1951

DISTRICT HEALTH OFFICE No. 4

File No. \_\_\_\_\_

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 \_\_\_\_\_

Licensed Embalmer No. 3873

P. O. Address St. Clair, 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.