

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43384

S. No. 300
V. 10.48

FILED JAN 10 1953

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11458**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		d. STREET ADDRESS (If rural, give location) 29 2919 S 18th	
3. NAME OF DECEASED (Type or Print) a. (First) Irene		b. (Middle) E	
c. (Last) Doyle		4. DATE OF DEATH (Month) (Day) (Year) Dec. 11, 1952	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb 6, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John Hoerner	
13b. MOTHER'S MAIDEN NAME Stella Reynolds		14. NAME OF HUSBAND OR WIFE Thaddeus Doyle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Thaddeus Doyle 2919 S 18th
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* (a) Pericardial Effusion 2yrs ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Paralytic Ileus II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 253X		22. I hereby certify that I attended the deceased from Nov 15, 1952 to Dec 11, 1952 , that I last saw the deceased alive on Dec 11, 1952 and that death occurred at 12:20 P.M. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) D. K. King		23b. ADDRESS 2500A Chippewa	
23c. DATE SIGNED 12/11/52		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 12/13/52		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	
24d. LOCATION (City, town, or county) (State) St Louis Co., Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J L Ziegenhein & Sons 7027 Gravois	
DATE REC'D BY LOCAL REG. DEC 12 1952		REGISTRAR'S SIGNATURE Carl Smith MO	

(Licensed Embalmer's Statement on Reverse Side)

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 B. J. Kudwiel

Licensed Embalmer No. 3877

P. O. Address 7027 Graves

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.