

FILED MAY 24 1954

# STANDARD CERTIFICATE OF DEATH

State File No. 16621

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 147

**1. PLACE OF DEATH**  
 a. COUNTY Marion  
 b. CITY (If outside corporate limits, write RURAL and give town) Hannibal  
 c. LENGTH OF STAY (In this place) \_\_\_\_\_  
 d. FULL NAME OF HOSPITAL OR INSTITUTION St. Elizabeth Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).  
 a. STATE Missouri b. COUNTY Marion  
 c. CITY (If outside corporate limits, write RURAL and give township) 1508 Grace St.  
 d. STREET ADDRESS (If rural, give location) Hannibal, Mo.

**3. NAME OF DECEASED**  
 a. (First) Berry b. (Middle) Earl c. (Last) Doyle, Sr.

**4. DATE OF DEATH** (Month) (Day) (Year)  
5-10-54

**5. SEX**  
 Male

**6. COLOR OR RACE**  
White

**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify)  
Married

**8. DATE OF BIRTH**  
10/27/1887

**9. AGE** (In years last birthday) 66  
 IF UNDER 1 YEAR: Months 6 Days \_\_\_\_\_  
 IF UNDER 24 HRS.: Hours \_\_\_\_\_ Min. \_\_\_\_\_

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)  
Railroad

**10b. KIND OF BUSINESS OR INDUSTRY**  
Retired

**11. BIRTHPLACE** (State or foreign country)  
Kentucky

**12. CITIZEN OF WHAT COUNTRY?**  
USA

**13a. FATHER'S NAME**  
William S. Doyle

**13b. MOTHER'S MAIDEN NAME**  
Fannie E. Davis

**14. NAME OF HUSBAND OR WIFE**  
Lucinda T. 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  
Mrs. Lucinda T. Doyle, 1508 Grace

**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, asphyxia, etc. It means the disease, injury, or complication which caused death.

**MEDICAL CERTIFICATION** Hannibal, Mo.  
**I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\*** (a) Terminal Bronchial pneumonia  
**ANTECEDENT CAUSES**  
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
 DUE TO (b) Chr. myocarditis, arteriosclerotic in type.  
 DUE TO (c) \_\_\_\_\_  
**II. OTHER SIGNIFICANT CONDITIONS**  
 Conditions contributing to the death but not related to the disease or condition causing death.

**INTERVAL BETWEEN ONSET AND DEATH**  
2 days

**19a. DATE OF OPERATION**  
 \_\_\_\_\_

**19b. MAJOR FINDINGS OF OPERATION**  
 \_\_\_\_\_

**20. AUTOPSY?**  
 YES  NO

**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)**  
Hannibal, Missouri

**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) (Min.)  
 \_\_\_\_\_

**21e. INJURY OCCURRED** WHILE AT WORK  NOT WHILE AT WORK

**21f. HOW DID INJURY OCCUR?**  
 \_\_\_\_\_

**22. I hereby certify that I attended the deceased from** Jan. 3, 1954, to 5/10/54, 1954, that I last saw the deceased alive on 5/10, 1954, and that death occurred at 4:00P am., from the causes and on the date stated above.

**23a. SIGNATURE** (Degree or title)  
[Signature] M.D.

**23b. ADDRESS**  
Hannibal, Missouri.

**23c. DATE SIGNED**  
5/17/54

**24a. BURIAL, CREMATION, REMOVAL** (Specify)  
Burial

**24b. DATE**  
5/13/54

**24c. NAME OF CEMETERY OR CREMATORY**  
Grand View Burial Pk.

**24d. LOCATION** (City, town, or county) (State)  
Hannibal, Mo.

**DATE REC'D BY LOCAL REG.**  
5/18/54

**REGISTRAR'S SIGNATURE**  
[Signature]

**25. FUNERAL DIRECTOR'S SIGNATURE** ADDRESS  
[Signature] Hannibal Mo

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

MAY 21 1954

RECEIVED

MARION CO. HEALTH DEPT.

DATE FILED

MAY 21 1954

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 *Michael J. O'Connell*

Licensed Embalmer No. 3246

P. O. Address Amesbury, Mass

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.