

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**6130**

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

No. 500  
10.48

**FILED FEB 25 1957**

BIRTH NO. 9570-5-1 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1241

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>Life</b>	c. CITY OR TOWN <b>St. Louis (15)</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>15 Lutheran Hospital</b>		STREET ADDRESS (If rural, give location) <b>2109 1233 West Farlin</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Mark</b> b. (Middle) <b>Edward</b> c. (Last) <b>Doyle</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>2-6-1957</b>		
5. SEX <b>0</b> <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>2-6-1957</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 14 HRS. Hours Min. <b>6 17</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>- -</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>0</b> <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>Samuel Doyle</b>	13b. MOTHER'S MAIDEN NAME <b>Alice Kathryn Ballard</b>	14. NAME OF HUSBAND OR WIFE <b>- - -</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No - -</b>	16. SOCIAL SECURITY NO. <b>- -</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Alice K. Doyle, 4233 W. Farlin (15)</b>	
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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) <b>Congenital Heart Disease</b>  ANTECEDENT CAUSES Morbid 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. <b>754.4</b>		INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? / YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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?

22. I hereby certify that I attended the deceased from 2-6-1957, 19, to 2-6-1957, 19, that I last saw the deceased alive on 2-6-1957, 19, and that death occurred at 5:45 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Hugh R. Smith M.D.</b>	23b. ADDRESS <b>100 N. Euclid</b>	23c. DATE SIGNED <b>2-7-1957</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>2/7/57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Mathews Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>FEB 7 '57</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b> <i>S.P.</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John H. Gebken Sons 2630 Gravois Ave.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

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 no Embalming, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert J. Gebken

Licensed Embalmer No. 414

P. O. Address 2630 4th

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.