

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045327
STATE FILE NUMBER

FILED JAN 13 1959 Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 495

1. PLACE OF DEATH a. COUNTY St Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Farmington St. Francois Twp. Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST CLAIR. Mo. Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp #45 weeks, 3 days. Length of stay in 1b		d. STREET ADDRESS (If outside, give location) home Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Edna Middle Mae Last Doyle			4. DATE OF DEATH Month Dec. Day 29 Year 1958		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1912	9. AGE (In years last birthday) 46	IF UNDER 1 YEAR Months 11 Days 10	IF UNDER 24 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME James W. Calvin	13b. MOTHER'S MAIDEN NAME Nancy C. Dearinger	NAME OF HUSBAND OR WIFE William Doyle
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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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT State Hospital No. 4, Farmington, Mo. William Doyle, St. Clair, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia		INTERVAL BETWEEN ONSET AND DEATH abt. 1 wk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Inanition	abt. 6 mos.
	DUE TO (c) 025X	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Psychosis with meningo-vascular syphilis (general paresis)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 1
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour 4:16 a.m. 025X Month, Day, Year	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from November 21, 1958 , to Dec. 29, 1958 and last saw her alive on Dec. 29, 1958 Death occurred at 4:16 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) John C. Brennan M.D.	22b. ADDRESS State Hospital No. 4 Farmington, Missouri	22c. DATE SIGNED 12-29-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 31, 1958	23c. NAME OF CEMETERY OR CREMATORY Stanton Cemetery	23d. LOCATION (City, town, or county) (State) Stanton, Missouri
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24. FUNERAL DIRECTOR ADDRESS Stemwood Kitchell St. Clair, Mo.	25. DATE REC'D. BY LOCAL REG. Jan. 9, 1959	26. REGISTRAR'S SIGNATURE Cather Rudloff
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(Licensed Embalmer's Statement on Reverse Side)

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

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JAN 23 1959

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
Signature of Student Embalmer

Signed *Sherrard W. Kitchell*

Licensed Embalmer No. *3873*
P. O. Address *St. Clair*

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.