

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028719

FILED VS SEP 14 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 948

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Laclede									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in lb 10 days		c. CITY OR TOWN Lebanon		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 162 N. Jackson		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First ALFRED Middle MADRIN Last DOYLE				4. DATE OF DEATH Month September Day 6 Year 1959									
5. SEX Male		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 Nov. 9, 1888		9. AGE (last birthday) 70		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (City and state or country) Dallas County, Missouri USA				12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME Daniel Boone Doyle				13b. MOTHER'S MAIDEN NAME Caroline Mills				14. NAME OF HUSBAND OR WIFE Tessie Doyle					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. 500-05-8182		17. INFORMANT Address Mrs. Elizabeth Fahn Lebanon, Missouri							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse Brain Damage DUE TO (b) subdural hematoma DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTEGRAL BETWEEN ONSET AND DEATH 8-7-59 to 9-6-59			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) 2 car accident, car struck from side									
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 8-7-59		Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Lebanon		20f. CITY, TOWN, OR LOCATION COUNTY STATE Lebanon MO			
21. I attended the deceased from 8-8-59 to 9-6-59 and last saw her him alive on 9-5-59 Death occurred at 12:30 A. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (In free or title) John P. K. King M.D.					22b. ADDRESS 1636 S. Glouster Springfield, Mo					22c. DATE SIGNED 9-8-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 8, 1959		23c. NAME OF CEMETERY OR CREMATORY Roach			23d. LOCATION (City, town, or county) (State) Roach, Missouri						
24. FUNERAL DIRECTOR ADDRESS Gorman-Scharpf Funeral Home Springfield, Missouri				25. DATE RECD. BY LOCAL REG. 9-9-59		26. REGISTRAR'S SIGNATURE Effie G. Melton							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 16 1959

OCT 14 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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lewis D. Schaefer

Licensed Embalmer No. 380

P. O. Address Springfield

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.