URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 0 1959

59-038995

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1161

MENDED

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Length of stay in 1b 40 years
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 1821 Clay St. — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 1821 Clay St. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First FRANK Middle THOMAS Last DOYLE

4. DATE OF DEATH Month Nov. Day 13, Year 1959

5. SEX male
6. COLOR OR RACE white
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH Jan. 29, 1896
9. AGE (last birthday) 63 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Public Offices
11. BIRTHPLACE (City and state or country) Bay City, Mich.
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Thomas Doyle
13b. MOTHER'S MAIDEN NAME Elizabeth McCauley
14. NAME OF HUSBAND OR WIFE Margaret Stockton Doyle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W. I & II
16. SOCIAL SECURITY NO. 524-07-2087
17. INFORMANT Address Mrs. Fannie Graham, R. R. #1, St. Joseph, Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH 1 DAY
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CARDIAC DECOMPENSATION — 2 WEEKS.
DUE TO (c)
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from JUNE 10, 1959, to NOV. 13, 1959 and last saw her/him alive on NOV. 12, 1959
Death occurred at NOV. 13, 1959 2:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] L. H. Pifer, M.D.
22b. ADDRESS BOLFARAON
22c. DATE SIGNED 11-16-59

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 11/17/1959
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) St. Joseph (State) Mo.

24. FUNERAL DIRECTOR Heaton-Bowman, ADDRESS St. Joseph, Mo.
25. DATE RECD. BY LOCAL REG. Nov. 24, 1959
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

US NOV 30 1959

US DEC - 2 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 William Spalding

Licensed Embalmer No. 4535

P. O. Address St Joseph, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.