

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 25 1960

-60-015267

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1951 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City Mo</u>		c. CITY OR TOWN <u>Kansas City Mo</u>	
Length of stay in lb <u>7 months</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Trinity Lutheran Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>511 W Meyer Blvd</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Mr Walter T.</u> Middle <u>Doyle</u> Last <u>Doyle</u>			4. DATE OF DEATH Month <u>April</u> - Day <u>5</u> - Year <u>1960</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u>	IF UNDER 24 HR Hours <u>3</u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor manager</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Eastman Kodak Co</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>T. S. Doyle</u>	13b. MOTHER'S MAIDEN NAME <u>Mary E Bryan</u>	13c. NAME OF HUSBAND OR WIFE <u>Minerva Doyle</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>336-05-5303</u>	17. INFORMANT <u>Mrs Irene Tucker</u>	Address <u>511 W Meyer Blvd</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Arteriosclerotic Heart Disease</u>	<u>5+ yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	<u>Generalized Arteriosclerosis</u>
	DUE TO (c)	<u>10+ yrs</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardiac Aneurysm</u>	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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 <u></u> a.m. <u></u> p.m. <u></u>	Month <u></u> Day <u></u> Year <u></u>
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20d. INJURY OCCURRED WHILE AT WORK <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 Nov 1959 to April 5 1960 and last saw him alive on April 4 1960  
Death occurred at 12:45 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W H Goodson, M.D.</u> (Degree or title)	22b. ADDRESS <u>730 Professional Bldg</u> <u>Kansas City 6 Mo</u>	22c. DATE SIGNED <u>Apr 5, 1960</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-7-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Moriah Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>
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24. FUNERAL DIRECTOR <u>France-Wornall Funeral Home Ke Mo</u>	ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>4-6-60</u>	26. REGISTRAR'S SIGNATURE <u>Newa Minshall</u>
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DOCUMENT

BY AFFIDAVIT OF H. GOODSON, MEDICAL CERTIFICATION

**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 James C Anderson, Student Embalmer No. 597  
working under my personal supervision.

Student James C Anderson  
Signature of Student Embalmer

Signed Russell N. France

Licensed Embalmer No. 4250

P. O. Address K.C. Mo

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.