

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033187

FILED SEP 7 1960 317 Primary Registration District No. 541 Registrar's No. 2559 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b> <b>CLAYTON MO</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>ST LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>CLAYTON</b>		Length of stay in 1b <b>DAYS</b>	c. CITY OR TOWN <b>LEMAY</b>
c. FULL NAME OF (If NOT in hospital, give location) <b>COUNTY HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2112 KEVIN</b>
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM C. DOYLE</b>			4. DATE OF DEATH Month Day Year <b>8-28-60</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-13-1914</b>	9. AGE (last birthday) <b>45</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL BUSINESS</b>	11. BIRTHPLACE (City and state or country) <b>JOVIAHAN, MO</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13a. FATHER'S NAME <b>HERMAN DOYLE</b>		13b. MOTHER'S MAIDEN NAME <b>EUNA BURNLEY</b>		14. NAME OF HUSBAND OR WIFE <b>_____</b>		

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>492-07-6451</b>	17. INFORMANT <b>MRS. BARBARA WILLIAMS 4018<sup>9</sup> CASTLEMAN</b>	Address
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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) <b>Bronchopneumonia</b>			<b>1 month.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Post operative craniotomy</b>		<b>1 yr.</b>
	DUE TO (c) <b>Far advanced meningioma</b>		<b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition (ven in PART I (a)) <b>Alcoholic, chronic</b>			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 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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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

21. I attended the deceased from **7-22-60** to **8-28-60** and last saw ~~him~~ <sup>her</sup> alive on **8-28-60**  
Death occurred at **11:45** m on the date stated above, and to the best of my knowledge, from the causes stated.

21. SIGNATURE (Degree or title) <b>Robert L. Howe M.D.</b>	22b. ADDRESS <b>601 S. BRENTWOOD BLVD</b>	22c. DATE SIGNED <b>8/29/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>8-31-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. LEBANON CEMETERY</b>
24. FUNERAL DIRECTOR <b>HOWARD M. MICHEL 5930 SOUTH HWEST</b>	25. DATE RECD. BY LOCAL REG. <b>8-29-60</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY, MO</b>		

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

**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 VE Morris

Licensed Embalmer No. 3360

P. O. Address St. La

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