ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-037516
STATE FILE NUMBER

AMENDED

Registration District No. 170 Primary Registration District No. — Registrar's No. 175

FILED OCT 24 1961

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Osage T.S. — Length of stay in 1b: 60 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Plato Star Rt. — Inside Limits: Yes ☐ No ☒

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

3. NAME OF DECEASED (Type or print): First William Middle Henry Last Doyel
4. DATE OF DEATH: Month Oct. Day 12, Year 1961
5. SEX: male
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10-16-76
9. AGE (last birthday): 84 — 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): farmer
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (City and state or country): MARIES COUNTY Marys County, Mo.
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: John Doyel
13b. MOTHER'S MAIDEN NAME: Lucinda Martin
14. NAME OF HUSBAND OR WIFE: Effie Mae Doyel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Effie M. Doyel, Address Plato Str. Rt. Lebanon, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
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 1957, to 10-12-1961 and last saw ~~him~~ her alive on 10-12-1961
Death occurred at 4:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H. Carrington, M.D. (Degree or title)
22b. ADDRESS Lebanon, Mo.
22c. DATE SIGNED 10-16-61

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 10-14-61
23c. NAME OF CEMETERY OR CREMATORY: Winnipeg Cemetery
23d. LOCATION (City, town, or county) (State): Laclede County, Mo.

24. FUNERAL DIRECTOR: D. Shadel — ADDRESS: Lebanon, Mo.
25. DATE RECD. BY LOCAL REG.: 10-16-1961
26. REGISTRAR'S SIGNATURE: Nella L. Hay

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | DOCUMENT | SHOULD READ | ITEM NO. | 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 me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 5115

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.