

Registration District No. **2029**

Primary Registration District No. **3043**

Registrar's No. **206**

1. PLACE OF DEATH:
 (a) County **Marion**
 (b) City or town **Hannibal**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **St. Elizabeth Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 in this community _____ years, months or days)

3. (a) PRINT FULL NAME **Hazel Kay Doyle**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **August 20, 1942**
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. **30** min.

9. Birthplace **Hannibal** **Missouri**
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name **Wilfred Doyle**

13. Birthplace **North Dakota**
 (City, town, or county) (State or foreign country)

14. Maiden name **Lois Tatman**

15. Birthplace **Missouri**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Tatman**

(b) Address **500 Wilson Hannibal**

17. (a) **Burial** (b) Date thereof **8/24/42**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mount Olivet**

18. (a) Signature of funeral director **Wm M Smith ecc**
 (b) Address **902 Broadway Hannibal**

19. (a) **8/28/42** (b) **R.W. Connor**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Marion**
 (c) City or town **Hannibal**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **500 Wilson**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **20**
 year **1942** hour **12** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **Aug. 20, 1942** to **Aug. 20, 1942**
 that I last saw her alive on **Aug. 20, 1942**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Premature Birth**
Lived 30 minutes

Due to _____

Due to _____

Other conditions **19**
 (include pregnancy within 3 months of death) **10**

Major findings: _____
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **H.D. Daniel** (M. D. certifying)
 Address **227 1/2 Broadway** Date signed **8-29-42**

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

..... **Not embalmed**, Registered Apprentice No.....
working under my personal supervision.

Signed.....

.....
Licensed Embalmer No.....

.....
P. O. Address.....

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 this body is not embalmed, fact should be so stated above.