

FILED AUG 8 1948 18
Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 Days**
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1611 Chestnut Street**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Elizabeth Doyle Twin #2**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **Negro**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
alive _____ years
7. Birth date of deceased **6 28 43**
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name **Gloria Doyle**
15. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Arthur M. Sherard, R.N.**
(b) Address **2601 N. Whittier Street**

17. (a) **Burial** (b) Date thereof **JUL 29 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CITY CEMETERY**

18. (a) Signature of funeral director **A. M. Sherman**
(b) Address **City of St. Louis**

19. (a) **Missouri** (b) _____
(Date of death) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **8**
year **43** hour **1** minute **45** P.M.

21. I hereby certify that I attended the deceased from **6 - 28** 19**43** to **7 - 8** 19**43**
that I last saw her alive on **7 - 8** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Prematurity Diarrhea**

Due to **Unknown**

Due to **Unknown**

Other conditions _____
(Include pregnancy within 3 months of death)

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)
(c) Means of injury _____

23. Signature **W. L. Smith** (M. D. or other) _____
Address **2601 N. Whittier Street** signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....
....., 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.