

FILED OCT 24 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
4004 Forest  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 50 Years  
years, months or days

3. (a) PRINT FULL NAME MRS. SARAH E DOYLE

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife James Doyle

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 7 1863  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>0</u>	<u>27</u>	hr. _____ min.

9. Birthplace Canada  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Patrick Malone

13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name No record

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

16. (a) Informant Miss Eileen Doyle

(b) Address 4004 Forest

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/44  
(Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cemetery

18. (a) Signature of funeral director Durkin and Robin Co.

(b) Address 20 West Linwood

19. (a) 10-6-44 (Date received local registrar)

(b) P. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 4004 Forest  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4th day Oct  
year 1944 hour 11:28 minute P M.

21. I hereby certify that I attended the deceased from Jan 2 1940, to 10-4 1944;  
that I last saw her alive on 10-4 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death nephritis

Due to hypertension  
secondary Renal disease

Due to \_\_\_\_\_

Other conditions 13/A  
(include pregnancy within 3 months of death)

Major findings:  
Of operations no

Of autopsy no

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 C

23. Signature N. H. Owens (M. D. or other MD)  
Address 1034 Realto Date signed 10-6-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed Charles M. Turk

Licensed Embalmer No. 3774

P. O. Address Kansas City 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 this body is not embalmed, fact should be so stated above.**