

FILED JUN 2 1945
Registration District No. 88

Primary Registration District No. 3017

State File No. _____

Registrar's No. 62

1. PLACE OF DEATH:

(a) County **COOPER**

(b) City or town **BOONVILLE - Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1136 SEVENTH STREET
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **22 YEARS** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **COOPER**

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

(d) Street No. **1136 SEVENTH ST.**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **WALTER OWEN DOYLE**

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **30th**
year **1945** hour **10:00** minute _____ P. M.

4. Sex **MALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

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

7. Birth date of deceased: **JANUARY 14 1879**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
that I last saw him alive on **never seen alive** _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion** Duration _____

8. AGE: Years Months Days If less than one day

66 4 16 hr. _____ min.

Due to _____

Due to _____

9. Birthplace **BUNCEPON MISSOURI**
(City, town, or county) (State or foreign country)

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

Major findings: Of operations _____

10. Usual occupation **RETIRED ICE & COAL OPERATOR**

Of autopsy **940**

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

11. Industry or business **ICE & COAL**

12. Name **UNKNOWN**

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

14. Maiden name **UNKNOWN**

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

16. (a) Informant **MRS W.O. DOYLE**

(b) Address **BOONVILLE, Mo.**

17. (a) **BURIAL** (b) Date thereof **6/1/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **WALNUT GROVE CEMETERY**

18. (a) Signature of funeral director **STEGNER & KOENIG**

(b) Address **BOONVILLE, MO.**

19. (a) **May 31 - 45** (b) **Dr. Chas. Swap**
(Date received local registrar) (Registrar's signature)

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 **Coronary**

23. Signature **J.P. Smith** (M.D. or other) _____
Address **913 - 7th St. Boonville Mo** Date signed **6/1/45**

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

27

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

6/1/45

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

James W. Segner

Licensed Embalmer No.

3780

P. O. Address

Boonville, 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.