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49110
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31828
9043

State File No.

Registrar's No.

Registration District No. 218

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital-Max G. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3625 No Bway
(If rural, give location) _____
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME CHARLOTTE DOYLE

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

4. Sex F. 5. Color or race nc 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Aug 4 1897
(Month) (Day) (Year)

8. AGE: Years 48 Months 2 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation Clerk

11. Industry or business _____

MOTHER FATHER

12. Name Wm Wiggins

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

14. Maiden name Edith Haeker
(City, town, or county) (State or foreign country)

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

16. (a) Informant Wm D Young

(b) Address 3400 N 11th. St.

17. (a) Burial (b) Date thereof 10/22/45
(Rural, cremation or removal) (Month) (Day) (Year)
(c) Place: National Clew-Jeff. Bks.

18. (a) Signature of funeral director Fendler Und Co.

(b) Address 7420 Michigan Ave

19. (a) OCT 19 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 18th
year 1945 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from 10/11/45
19____ to 10/18/45 19____
that I last saw her alive on 10/18/45 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Fibrous Pulmonary Tuberculosis
& Bronchopneumonia

Due to _____
Due to _____

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

Major findings: Of operations _____

Of autopsy Same

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Herbert C. Fritz (M. D. or other) _____
Address 1515 Lafayette 10/28/45 signed _____

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.....

W E Morris

Licensed Embalmer No.....

3360

* 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.