

No. 2
-8-43
17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12123

FILED APR 19 1946

State File No. _____

Registration District No. 11

Primary Registration District No. 4023

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Exeter
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 7
(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)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21
year 1945 hour 8 minute P. M.

21. I hereby certify that I attended the deceased from Mar. 17 1945 to Mar. 21 1946
that I last saw him alive on Mar. 21 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Embolus. Duration 1/2 hr.

Due to: Chronic Myocarditis. 12 yrs.

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

Major findings:
Of operations

Of autopsy

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) _____
Means of injury _____

23. Signature E. M. Ray (M.D. or other) abdo 2
Address Cassville, Mo. Date signed 3/25/46

3. (a) PRINT FULL NAME Robert L. Doyle

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

4. Sex Male 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 November 9 1866
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 12
If less than one day hr. _____ min.

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

10. Usual occupation Farmer & Stockraiser

11. Industry or business _____

12. Name Isaac Doyle

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

14. Maiden name Mary Elizabeth Marsen

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

16. (a) Informant P. P. Doyle

(b) Address Exeter, Missouri

17. (a) Burial (b) Date thereof 3-24-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maplewood Cemetery

18. (a) Signature of funeral director Culver Funeral Home

(b) Address Cassville, Mo.

19. (a) April 1-1946 (b) Grace Williams
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6

District File Number 446-459

Date Filed APR 16 1946

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 Margaret Culver

Licensed Embalmer No. 4389

P. O. Address Cassville

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.

Registration District No. 11

Primary Registration District No. 4023

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Exeter
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Robert L. Doyle

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 79 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Farmer and Stock raiser

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

(b) Address _____

19. (a) April 29 - 1946 Grace Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 21
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

12123