

No. 2
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17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27169**

FILED SEP 11 1947

Registration District No. **82**

Primary Registration District No. **3017**

Registrar's No. **130**

1. PLACE OF DEATH:

(a) County Cooper

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

(c) Name of hospital or institution:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether in this community 4 Years years, months or days)

3. (a) PRINT FULL NAME Mrs. Josephine Doyle

3. (b) If veteran, name war ****

3. (c) Social Security No. ****

4. Sex Female

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased Nov. 1 1912
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>34</u>	<u>8</u>	<u>8</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name L. L. Collier

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

14. Maiden name Lucinda M. Murray

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

16. (a) Informant James Doyle

(b) Address Bunceton Mo.

17. (a) Burial (b) Date thereof Aug 11 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill Sedalia Mo.

18. (a) Signature of funeral director Goodman & Boller

(b) Address 505 Main Boonville Mo.

19. (a) 8-11-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cooper

(c) City or town Bunceton Mo.
(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 Aug day 9
year 1947 hour 11:50 minute P M.

21. I hereby certify that I attended the deceased from Mar 2 1947 to Aug 9 1947
that I last saw her alive on Aug 9 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Eclampsia Duration 1 day

Due to acute nephritis
Hypertension

Other conditions Pregnancy (full term)
(Include pregnancy within 3 months of death)
(Stillbirth - 8.9.47)

Major findings: none

Of operations: none

Of autopsy: none

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?

23. Signature J. C. Beckett (M. D. or other) MD

Address Boonville Mo. **Date signed** 8-11-47

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

MOTIVEL FATHER

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 9-10-47

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 _____

Wm W Wood, Registered Apprentice No. 480
working under my personal supervision.

Signed G. F. Baller

Licensed Embalmer No. 3062

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.