No. 2
1/47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED SEP 23 1947
Registration District No. 31

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3063

State File No. 29714 0✓
Registrar's No. 1782

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

1. PLACE OF DEATH:
(a) County St. Louis County
(b) City or town Clayton, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis Co. Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Months 23 Days (Specify whether)
In this community 9 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town Ferguson 6 (If outside city or town limits, write "RURAL")
(d) Street No. Claremont Drive 2 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME John 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 Married
6. (b) Name of husband or wife Beulah
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 3 (Month) - 9 (Day) - 1893 (Year)

8. AGE: Years 54 Months 5 Days 6 If less than one day hr. min.
9. Birthplace Shelby County, Alabama (City, town, or county) (State or foreign country)
10. Usual occupation Red cross
11. Industry or business
FATHER
12. Name James Doyle
13. Birthplace Alabama (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Ann Talley
15. Birthplace Alabama (City, town, or county) (State or foreign country)
16. (a) Informant Beulah Doyle
(b) Address Claremont Dr. Ferguson
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-47 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem.
18. (a) Signature of funeral director Math. Hermann & Son
(b) Address 2161 Fair Ave. St. Louis
19. (a) 8-19-47 (Date received local registrar) (b) Beula J Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15th year 1947 hour 5 minute 10 P.M.
21. I hereby certify that I attended the deceased from May 23rd, 1947 to August 15th, 1947 that I last saw him alive on August 15th, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	
Due to Multiple myeloma	
Due to 55 ✓	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Multiple myeloma	

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature Wilson G Brown (M. D. or other) MD
Address Date signed

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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. Lloyd G. Burnley

Licensed Embalmer No. 4202 C

P. O. Address St Louis 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.

No. 2B
—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 1782

1. PLACE OF DEATH:

(a) County St Louis County

(b) City or town Clayton
(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)

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

3. (a) PRINT FULL NAME John 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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 9 (Day) 1894 (Year)

8. AGE: Years 54 Months 5 Days 6 If less than one day hr. min.

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

10. Usual occupation Lehman

11. Industry or business Red Cross

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Day
year 1947 hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h 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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-29714