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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38050**

FILED DEC 2 1948

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10008**

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 C. Starkloff
(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 ELISE DOYLE

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female / 5. Color or race White / 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wm. P. Doyle / 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased December 26, 1892
(Month) (Day) (Year)

8. AGE: Years 55 Months 10 Days 20 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER { 12. Name Frank Walter

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

14. Maiden name Caroline Willman

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

16. (a) Informant Mr. William P. Doyle

(b) Address 3669 Montana

17. (a) Burial (b) Date thereof 11-20-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park
Southern Funeral Home

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

(b) Address 6322 S. Grand Blvd.

19. (a) NOV 18 1948 (b) J. B. Savater
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3669 Montana
Memorial (If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16th
year 1948 hour 5 minute 40 P. M.

21. I hereby certify that I attended the deceased from 11/8/48
....., 19....., to Nov. 16th, 19.....
that I last saw h. or alive on Nov. 16th, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to Cerebral vascular thrombosis

Due to.....

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

Major findings:
Of operations.....

Of autopsy left parietal meningitis
bronchopneumonia

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)

(c) Means of injury.....

23. Signature Wm. P. Doyle (Physician's name)
1515 Lafayette 11/17/48
Address Date 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 *J. W. M. Temple*
Licensed Embalmer No. *3653*
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.