

FILED NOV. 22, 1954
Miss. Collier.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38010**

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **347**

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) Hannibal		c. CITY OR TOWN Hannibal	
d. FULL NAME OF HOSPITAL OR INSTITUTION Levering Hospital		e. STREET ADDRESS (If rural, give location) 314 Mark Twain Ave.	

3. NAME OF DECEASED a. (First) Andrew b. (Middle) Jackson c. (Last) Doyle		4. DATE OF DEATH (Month) (Day) (Year) 11-15-54	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 5/9/1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 81
		11. BIRTHPLACE (City and State or Foreign Country) Kentucky	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE Sarah Katherine Doyle
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Sarah Katherine Doyle ADDRESS 314 Mark Twain

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None by postmortem procedure		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (a.e., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **11/11** 19**54**, to **11/15** 19**54**, that I last saw the deceased alive on **11/15** 19**54**, and that death occurred at **5:00A** m., from the causes and on the date stated above.

23a. SIGNATURE A. J. Boen (Degree or title)	23b. ADDRESS Hannibal, Mo.	23c. DATE SIGNED Nov 15/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/17/54	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	24d. LOCATION (City, town, or county) (State) Hannibal, Mo.
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DATE REC'D BY LOCAL REG. 11/15/54	REGISTRAR'S SIGNATURE W. E. M. Luke	189-2	5. FUNERAL DIRECTOR'S SIGNATURE Michael J. O'Donney ADDRESS Hannibal, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED NOV 18 1954
MARION CO. HEALTH DEPT
DATE FILED NOV 18 1954

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Michael J. O'Honnell*

Licensed Embalmer No. *324*

P. O. Address *Hannibal*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.