Health, Welfare Public Service

S. 300
. 1-56

FILED MAY 15 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

15628
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1068

1. PLACE OF DEATH a. COUNTY St.Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights — Inside Limits Yes ☒ No ☐	c. CITY OR TOWN St.Louis — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 33 St.Mary's Hospital — Length of stay in lb 7-days 9	d. STREET ADDRESS (If outside, give location) 17 2005 S.Grand Blvd. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First: Anne	Middle: S.	Last: Doyle
4. DATE OF DEATH	Month: April	Day: 21	Year: 1957
5. SEX: F.	6. COLOR OR RACE: W.	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: Oct.11,1887
9. AGE (In years last birthday): 69	IF UNDER 1 YEAR: Months 6 Days 10	IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife-at home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Ills.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Hugh Higgins		14. MOTHER'S MAIDEN NAME: Mary Rose Fitzgerald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT Address: Mr.F.James Doyle,2005 S.Grand Blvd.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma bladder
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) C Metastases
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 181X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 15 apr 57, to 21 apr 57 and last saw her/him alive on 21 apr
Death occurred at 8 pm. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Gray Stawor MD	22b. ADDRESS: 4660 Maryland	22c. DATE SIGNED: 4-23-57
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: April 24,1957	23c. NAME OF CEMETERY OR CREMATORY: St.Mary's Cemetery
23d. LOCATION (City, town, or county) (State): Chicago,Ills.		
24. FUNERAL DIRECTOR: Arthur J. Donnelly	ADDRESS: 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG.: 4-23-57
26. REGISTRAR'S SIGNATURE: Herbert A. Domke MD		

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Francis Willia

Licensed Embalmer No. 35

P. O. Address 38 to L

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.