

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026566

FILED VS AUG 5 1959

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STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Length of stay in 1b <u>22 yrs. 5 Mo.</u> <u>5 days.</u>		c. CITY OR TOWN <u>St. Louis, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis State</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4977 Magnolia</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>GENEVIEVE</u> Middle Last <u>DOYLE</u>			4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-92</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>formerly: Stenographer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME <u>Godfrey Lazar</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Hansenn</u>	14. NAME OF HUSBAND OR WIFE <u>Ralph Doyle</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mrs. Ralplene Gerding, 141 Bayview (35)</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Confluent bronchopneumonia with abscesses</u> <u>bilateral</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) <u>Generalized arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was she a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from February 22, 1937 to July 27, 1959 and last saw her ^{her} _{him} alive on July 27, 1959
Death occurred at 4:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>C. A. Valtierra, M.D.</u> (Degree or title)	22b. ADDRESS <u>5400 Arsenal St.,</u>	22c. DATE SIGNED <u>7-27-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 30, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Old St. Marcus Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Beiderwieden F.H.Inc., 1936 St. Louis</u>	25. DATE RECD. BY LOCAL REG. <u>JUL 28 '59</u>	26. REGISTRAR'S SIGNATURE <u>Head Smith, M.D.</u> <u>mab</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF MISSOURI
DEPARTMENT OF HEALTH

STATEMENT BY LICENSED EMBALMER

STATE OF MISSOURI

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

for by X _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Homer W. Fritz

Licensed Embalmer No. 3882

P. O. Address St. Louis

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