

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036087

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9383**

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 1 1 1962

VS 300
Rev. 4/59

1

2 **20**

3

4 **0**

5 **1**

6

7 **0**

8 **2**

9

10

11

12 **68-0**

13

DATE AMENDED
2
INSTEAD OF
68
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 30 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5233 Robin				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle A Last DOYLE Sr.						4. DATE OF DEATH Month September Day 28 Year 1962					
5. SEX male		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4/4/1905		9. AGE (last birthday) 57 years		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) lathe operator				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13a. FATHER'S NAME Andrew Doyle				13b. MOTHER'S MAIDEN NAME Elizabeth Raab				14. NAME OF HUSBAND OR WIFE Edna Doyle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Edna Doyle - 5233 Robin					
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Perforated duodenal ulcer and DUE TO (c) Hemorrhagic Perforated Cholecystitis								INTERVAL BETWEEN ONSET AND DEATH 16 hrs			
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 there a pregnancy in last 90 days. 541.1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)							
20c. TIME OF INJURY Hour Month, Day, Year s.m. p.m.		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	
21. I attended the deceased from 21 Sept 62 to 28 Sept 62 and last saw her 28 Sept 62 and last saw him alive on 28 Sept 62 Death occurred at 7:01 AM on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) J. R. Dalton M.D.						22b. ADDRESS 453 N. Doyle, St. Louis, Mo			22c. DATE SIGNED 10/1/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE Oct 1, 1962		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) St. Louis County		23e. STATE Missouri			
24. FUNERAL DIRECTOR BUCHHOLZ MORTUARY-5967 W. Florissant Ave						25. DATE RECD. BY LOCAL REG. OCT 1 1962		26. REGISTRAR'S SIGNATURE Lead Smith M.D.			

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MISSOURI

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 Ralph E. Findler

Licensed Embalmer No. 4275

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