MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

13225

1. PLACE OF DEATH

County.....

Township.....

City.....

Registration District No. 791

Primary Registration District No. 1003

File No.....

Registered No. 3521

(No. 4921a Maple av St. ..... Ward)

2. FULL NAME Robert James Boyle

(a) Residence. No. 4921a Maple av. St., 12 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	white	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 4 1921

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	6	2	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER James E. Boyle

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Bertha Lasher

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

14. INFORMANT James E. Boyle
(Address) 4921a Maple av

15. FILED FEB 12 1927 19 Max C. Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 11 1927

17. I HEREBY CERTIFY, That I attended deceased from April 11 3 PM, 1927, to April 11, 1927 that I last saw him alive on April 11 5 PM, 1927, and that death occurred, on the date stated above, at 6 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Empacted bowel
Enter colitis
with Convulsions

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 1148

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C M Thuckmorton, M. D

, 19 (Address) 1741 Cora ave

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Valhalla Cem.

DATE OF BURIAL: April 13 1927

20. UNDERTAKER: Philander Craig

ADDRESS: 1238 Wild Kingshighway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

...WITH UNFADING INK—THIS IS A PERMANENT RECORD

HM 5077