

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

Do not use this space.

22619

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1008

City *St. Louis*

5800 Arsenal St.

File No.....

Registered No.....

6848

St. Ward)

2. FULL NAME

Patrick Joyce

(a) Residence. No. *5800 Arsenal* St., *13* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (or by the word)

single

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

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

Unknown

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

abt. 69

8. OCCUPATION OF DECEASED

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

Pipe Fitter

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

City Infirmary

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

10. NAME OF FATHER

Patrick Joyce

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Nolan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

14.

INFORMANT

(Address)

*Nared Holbrook
5800 Arsenal St.*

15.

FILED

MAILED

*30 1028
May C. Stankoff*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

June 28 1928

17.

I HEREBY CERTIFY That I attended deceased from *May 19 1928* to *June 28 1928*, that I last saw him alive on *June 28 1928*, and that death occurred, on the date stated above, at *11:30 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

93C Ch. Myocarditis

99

90B

CONTRIBUTORY (SECONDARY)

General Arteriosclerosis

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH.

DATE OF.....

NO

WHAT TEST CONFIRMED DIAGNOSIS.....

Clinical

(Signed).....

Edward Melberry, M.D.

, 19 (Address).....

W. Mo

*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

DATE OF BURIAL

Not Olney Cemetery

6/30 1928

20. UNDERTAKER

ADDRESS

Southern N. I. Co

7315 S. Broadway

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.

WHILE FULFILLING THIS IS A PERMANENT RECORD

