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

Do not use this space.

31805

File No. 9059

Registered No.

1. PLACE OF DEATH

County ..... Registration District No. 48

Township ..... Primary Registration District No. 400

City Texas (No. City Hospital St. ..... Ward)

2. FULL NAME 8897 Jacob Boley

(a) Residence. No. 3130 Iowa St. 24 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Cohly
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 16 — 1856

7. AGE: Years 72 Months 5 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Day Laborer
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Jacob Boley Sr
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Scotland
12. MAIDEN NAME OF MOTHER: Elizabeth Sesson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): France

14. INFORMANT: Hospital Information
(Address): E. Roman City Hospital

15. FILED SEP 10 1927, 19 ..... Max Stanley Registrar

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 9 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 6, 1928, to Sept 9, 1928, that I last saw him alive on Sept 9, 1928, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ch. Myocarditis &
Mitral Stenosis
(Duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Ch. Int. Nephritis
(Duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? No

DIDIAN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R. Berg, M. D.

9/9, 1928 (Address) City Hospital

*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: Allenton Missouri
DATE OF BURIAL: 9/12 1928

20. UNDERTAKER: Kingshauser Und Co
ADDRESS: 4104 Manchester

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.

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