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

Do not use this space.

5532

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1. PLACE OF DEATH
County: Buchanan
Registration District No.:
Township:
Primary Registration District No.: 1001
City: So. Joseph (No. Sate Hospital #2. St. Ward)

File No.:
Registered No.: 197

2. FULL NAME: Coleman Hoyle

(a) Residence. No. St., Ward. Kansas City, Mo.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) About 1898

7. AGE: Years 31 | Months Unknown | Days | 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):
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Thomas W. Hoyle
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Lillie Gibens
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Missouri

14. INFORMANT State Hosp. Records.
(Address) St. Joseph Mo.

15. FILED FEB 16 1929, 19
John G. Ott
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 15 1929

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1926 to Feb 15, 1929, that I last saw h. alive on 7 P.M., 19, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Paralysis of Insane
(duration) 4 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Convulsions
(duration) yrs. 6 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? Clinical
(Signed) J. A. Jeanick, M. D.
15th Feb. 1929 (Address) St Joseph 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: Kansas City, Mo.
DATE OF BURIAL: Feb, 17, 1929

20. UNDERTAKER: Walter Meierhoffer
ADDRESS: 1302 Faraon St.

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.

WRITE PLAINLY, WITH UNFADING INK. DO NOT FOLD. DO NOT WRITE OUTSIDE THIS MARGIN.

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