

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

Do not use this space.

6742

1. PLACE OF DEATH

County Jackson
 Township Ham
 City Kansas City (No. 115 W Armour Blvd)

Registration District No. 399
 Primary Registration District No. 1002

File No. 300
 Registered No. 300
 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 115 W Armour Blvd St. 5 Ward _____
 (Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 10th 1873

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>55</u>	<u>6</u>	<u>12</u>	

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) Pa

10. NAME OF FATHER

Dont Know

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Dont Know

12. MAIDEN NAME OF MOTHER

Dont Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Dont Know

14.

INFORMANT B E Boyle
 (Address) 115 W Armour Blvd

15.

FILED 2-24-29 M M Crow
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/23/29 1929

I HEREBY CERTIFY, That I attended deceased from Jan. 4 1929 to Feb 23 1929 that I last saw her alive on Feb 23 1929, and that death occurred, on the date stated above, at 9:20 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uremia
131
1320 (duration) yrs. 1 mos. ds.
 CONTRIBUTORY (SECONDARY) Chronic Nephritis & Hypertension (duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Chrical

(Signed) H. P. Thompson, M. D.

A-25, 19 29 (Address) 924 Piact. Bldg

*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

Calvary Cem 7/25/29 1929

20. UNDERTAKER

ADDRESS

H. F. Mayberry Co City Mo

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—THIS IS A PERMANENT RECORD

235
 2
 91
 91

1200
10
974 (Kis)