

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

Do not use this space.

24582
2993

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399

Primary Registration District No. 1002

File No. _____
Registered No. _____
St. _____ Ward) _____

2. FULL NAME

Thomas Boyle

(a) Residence No. 4536 Mercier St. 7 Ward.

(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs. 7 mos. 7 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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) April 1 1876

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	53	3	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Welder
(b) General nature of industry, business, or establishment in which employed (or employer) K.C. Pub. Serv. Co.
(c) Name of employer _____

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

10. NAME OF FATHER Thomas Boyle

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

12. MAIDEN NAME OF MOTHER Bridget Lyons

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

14. INFORMANT Re wood Clerk
(Address) K.C. General Hosp.

15. FILED 7/9 1929 M M Crowe
asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-8 1929

17. I HEREBY CERTIFY, That I attended deceased from 5-21 1929 to 7-8 1929, that I last saw him alive on 7-8 1929 and that death occurred, on the date stated above, at 4:30 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
75C

CONTRIBUTORY (SECONDARY) 90B
(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 TO (AGNOSIS) Chloroform
(Signed) P. B. Williams M. D.

(Address) Sept K.C. Gen. Hosp.
*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 Franklin Mo. DATE OF BURIAL 7-10 1929

20. UNDERTAKER W F Mayberry ADDRESS W. B. City, Mo.

WHITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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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