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

Do not use this space.

16085

1. PLACE OF DEATH
County Jackson
Township Kaw
City Kansas City (No. 2300 College St. Ward)
Registration District No. 399
Primary Registration District No. 1002
File No. 1993
Registered No.

2. FULL NAME Mary Leta Hoyle
(a) Residence. No. St. Anthony's Home St., 11 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
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) 2-24-30.

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	2	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER John Hoyle
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) not Known
12. MAIDEN NAME OF MOTHER Leta Hoyle
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) not Known

14. INFORMANT Sister M. Joseph
(Address) St. Anthony's Home

15. FILED 5/9, 1930 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 7 1930

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1930, to May 7, 1930 that I last saw her alive on May 7, 1930, and that death occurred, on the date stated above, at 6:31 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho-pneumonia
107A
159 (duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) Premature birth
(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 DIAGNOSIS? —
(Signed) Alipio Casilao, M. D
5/8, 1930 (Address) St. Anthony's Home

*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 St. Anthony's Cemetery
DATE OF BURIAL May 10 1930

20. UNDERTAKER John W. Wagner
ADDRESS 1409 Grand ave

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.

WHITE PLANET WITH UNFADING INK—THIS IS A PERMANENT RECORD