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

Do not use this space.

18099

File No. 5257

Registered No.

1. PLACE OF DEATH

County

Registration District No. 791

Township

Primary Registration District No. 1003

City St. Louis Mo (No. City Sanitarium St. Ward)

2. FULL NAME Thomas Boyer

(a) Residence. No. 6103 So. Broadway St., 13 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 13, 1877

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	53	4	15	

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) Unknown
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Washington Co.
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Washington Co.
(STATE OR COUNTRY) Missouri

14. INFORMANT Louis H. Kohlus
(Address) 5420 Ahrens

15. MAY 29 1930 (FILED 19) May C. Starler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/28/30 19

17. I HEREBY CERTIFY, That I attended deceased from 5/20/29, 19, to 5/28/30, 19, that I last saw h. alive on 5/28/30, 19, and that death occurred, on the date stated above, at 12:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Dementia Paralytica
93
34
(duration) 1 yrs. mos. 9 ds.

CONTRIBUTORY (SECONDARY) Syphilis
(duration) 1 yrs. mos. 9 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 & Laboratory
(Signed) Louis H. Kohlus, M. D.
5/28/30 19 (Address) 5420 Ahrens

*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 Mount Hope Cem. DATE OF BURIAL 5/30 1930

20. UNDERTAKER C. Hoffmeister & Co. ADDRESS 1818 S. Broadway

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.