

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

Do not use this space.

19679

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Ray Primary Registration District No. _____
 City W.C. Mo. (No. Branch Lutheran St. _____ Ward) _____

2. FULL NAME

Charles Amos Boyles
 (a) Residence, No. Levington, 270 St. _____ 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 <u>Male</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Rosalie Boyles</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec-15-19-1887</u>					
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.	
	40	6	14		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>Coal Miner</u>					
(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) <u>Missouri</u>					
PARENTS	10. NAME OF FATHER <u>Peter S. Boyles</u>				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Ohio</u>				
	12. MAIDEN NAME OF MOTHER <u>Manda Miranda</u>				
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Missouri</u>				
14. INFORMANT <u>Rosalie Boyles</u> (Address) <u>Levington, Mo.</u>					
15. FILED <u>6/29 1930</u> M. M. Brown REGISTRAR					

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 29-1930

17. I HEREBY CERTIFY, That I attended deceased from June - 28, 1930, to June - 29, 1930.
 That I last saw him alive on June - 29, 1930, and that death occurred, on the date stated above, at 6 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Perforated Gastric Ulcer
11757
1930
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Pertussis from gastric content
 (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? Yes
 WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
 (Signed) Ray U. Stephens M. D.
6/29 1930 (Address) 910 North 10th

*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 June 29, 1930
Levington, Mo.

20. UNDERTAKER Mrs. C. T. Foster ADDRESS W.C. 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.

W. H. ...
O. J. ...
1112 Edmontwy VA-3646

Dr. R. V. Steen

910 Pinalta Ma-0840

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