

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

Do not use this space.

16888

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis Mo.* (No.)

Sanitarium St. Ward)

File No.

Registered No. **4831**

2. FULL NAME

Michael Boland

(a) Residence. No. *St. Vincent's Hospital St.* **13** Ward.

Length of residence in city or town where death occurred *66 yrs. + mos.*

How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5-22-1927*

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

17. I HEREBY CERTIFY, That I attended deceased from *12-1-1925*, to *5-22-1927*, that I last saw him *alive* on *5-22-1927*, and that death occurred, on the date stated above, at *4:45 P. M.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *About 75*

Chronic myocarditis

-8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Unknown*
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer "

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

IF NOT AT PLACE OF DEATH?.....

10. NAME OF FATHER *John Boland*

9 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

10 WAS THERE AN AUTOPSY?.....

12. MAIDEN NAME OF MOTHER *Johanna Gleason*

11 WHAT TEST CONFIRMED DIAGNOSIS? *no*

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

(Signed) *R. H. Russell*, M. D.

14. INFORMANT *R. H. Russell* (Address) *City Ave*

12 *5-22, 1927* (Address) *City Ave*

15. *Max B. Starkloff* REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Calvary*

20. UNDERTAKER *Arthur J. Donnelly*

DATE OF BURIAL *5-24 1927*

ADDRESS *2039 Wash St*

FILED *23 1927*

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.

