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

Do not use this space.
10893 10843

1. PLACE OF DEATH
County Jackson
Township Kaw
City K.C. Mo. (No. 2119 Summit St. Ward)
Registration District No.
Primary Registration District No.
File No.
Registered No. 1403

2. FULL NAME Joseph Ray Doyle
(a) Residence No. 2119 Summit St., 3 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 9 1883

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ___ hrs. or ___ min.
45	5	13	

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)
(c) Name of employer

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9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ills.

PARENTS

10. NAME OF FATHER Christ Doyle
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio
12. MAIDEN NAME OF MOTHER No Record
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) No Record

14. INFORMANT Edna Doyle
(Address) 2119 Summit St.

15. FILED 3/22, 1929 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mch, 22 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar. 19, 1929, to Mar. 22, 1929 that I last saw him alive on Mar 21, 1929, and that death occurred, on the date stated above, at 7:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epidemic lumbo spinal meningitis
13
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Unknown
(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? Physical exam

(Signed) [signature] M.D.
3/22 1929 (Address) 1303 Waldheim Bldg. K.C. Mo.

*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: Forest Hill
DATE OF BURIAL: Mch 23 1929

20. UNDERTAKER: Mrs. C. L. Forster
ADDRESS: K.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.

THIS IS A PERMANENT RECORD