

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

Do not use this space.

11143

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City St. Louis Mo (No. 4228 McRee)

File No.....  
Registered No. 3180  
St. .... Ward)

**2. FULL NAME** John P. Boyle

(a) Residence No. 4228 McRee St. 17 Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 40 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) Widowed

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

Elizabeth Boyle

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-15-1860

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
	<u>69</u>	<u>5</u>	<u>12</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Oilier  
(b) General nature of industry, business, or establishment in which employed (or employer) Railroad Engin  
(c) Name of employer Mo. Pac.

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Scotland

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Myrtle Brown  
(Address) 4228 McRee

15. FILED 30, 1931 May C. Parker REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-27-30 19

17. I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1929, to Dec 26, 1930 that I last saw him alive on Mar 25, 1930, and that death occurred, on the date stated above, at 9 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Nephritis (Chronic Interstitial)  
Myocarditis (Chronic)  
131  
93c (duration) yrs. ? mos. ds.

CONTRIBUTORY (SECONDARY) Myocarditis  
(duration) yrs. ? mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH 129 W

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Labatory + Clinical  
(Signed) W. E. Jewell, M. D.

, 19 (Address) 5930 Southwest

\*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 Mt Hope Cemetery DATE OF BURIAL 3-31-30

20. UNDERTAKER McLaughlin 1631 mo ave ADDRESS

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.

