

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City, *St Louis Mo* (No. *Christian Hosp*)

Registration District No. *7911*
Primary Registration District No. *1003*

File No. *41363*
Registered No. *12041*
St. Ward)

2. FULL NAME *Milton Broyles*

(a) Residence. No. *1223 Clinton St* St. *26* Ward. (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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Not known*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 67

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER *John Broyles*

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

12. MAIDEN NAME OF MOTHER *Not known*

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

14. INFORMANT *Frank Broyles*
(Address) *1223 Clinton St*

15. FILED *26 1930* *Max C Stank* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 24 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Dec 18*, 19*30*, to *Dec 24*, 19*30* that I last saw him alive on *Dec 24*, 19*30* and that death occurred, on the date stated above, at *12 noon* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Intestinal Nephritis
150 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *1290* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *John A Cook* M. D.

19. (Address) *5748-A W. Florissant*

*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 *Brissac Mo.* DATE OF BURIAL *Dec 26 1930*

20. UNDERTAKER *Boyd Leidner and Co. St. Mark* ADDRESS *1419*

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.

