

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

Do not use this space.

SEP 20 1934

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 29598
 Township St. Louis Primary Registration District No. 1002 Registered No. 40117
 City St. Louis (No. General Deep #2) St. 3rd Ward

2. FULL NAME

(a) Residence, No. 128 Mission Ave Ward. (If nonresident, give city or town and State)
 (Usual place of abode)

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 Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-1-1892

7. AGE YEARS 61 MONTHS 8 DAYS 28 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Unemployed
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —
 10. Date deceased last worked at this occupation (month and year) Mo. 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER FATHER 13. NAME James Doyle

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

15. MAIDEN NAME Fessie Kauf.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kans.

17. INFORMANT (ADDRESS) General Clerk

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Louis DATE 8/31/34 19.

19. UNDERTAKER (ADDRESS) West Capital City

20. FILED 8/30 1934 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-29 1934

22. I HEREBY CERTIFY, That I attended deceased from 8-25 1934, to 8-29 1934

I last saw him alive on 8-29 1934 Death is said to have occurred on the date stated above, at 7:00 P.M.

The principal cause of death and related causes of importance were as follows:

Bilateral Pulmonary Edema Date of onset 34
Specific Heart Disease Date of onset 34

Other contributory causes of importance: —

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____

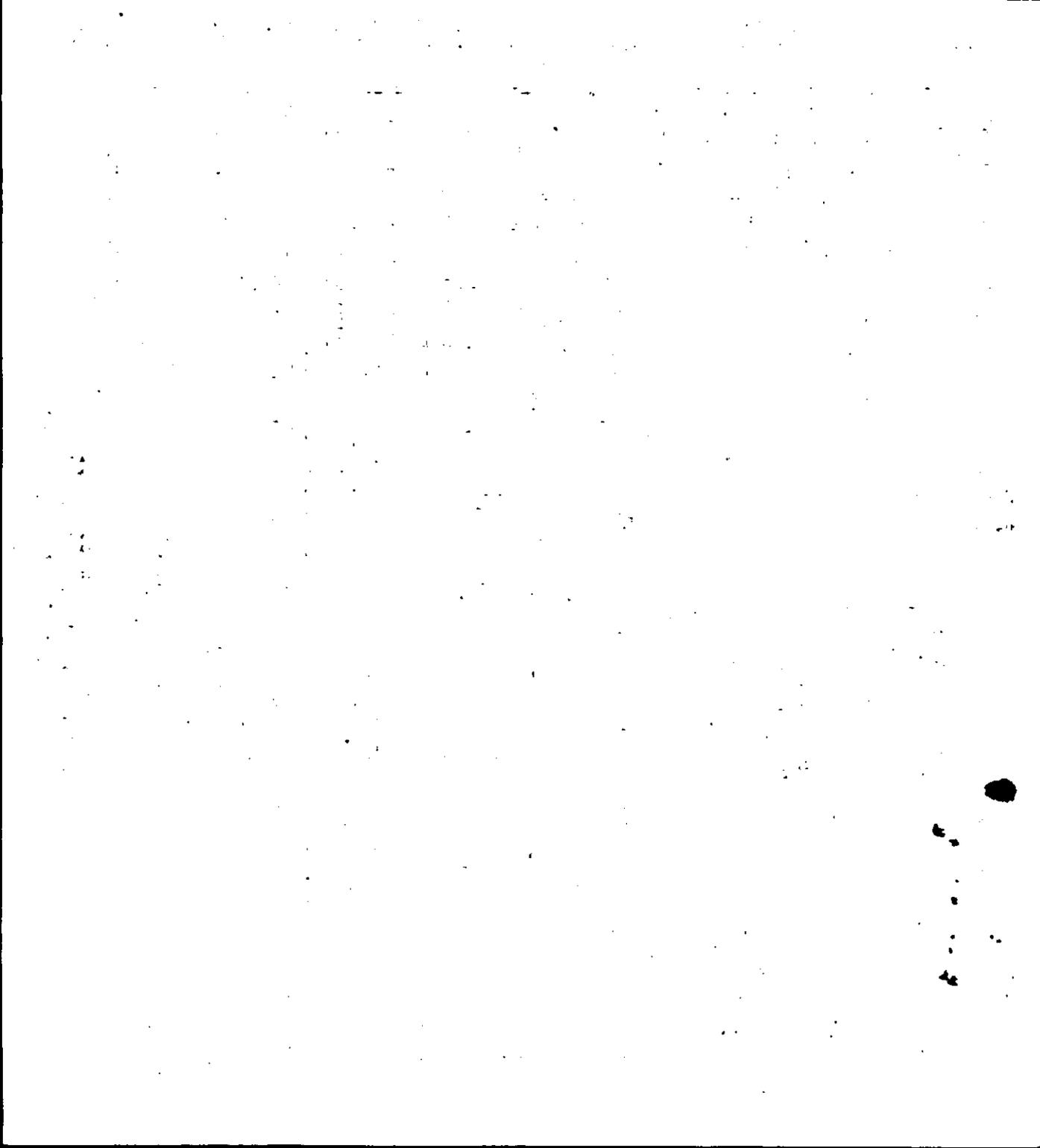
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? Yes

If so, specify _____

(Signed) B. O. Jones M.D.
 (Address) Central Deep #2

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.



4017

1 Kansas City

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Edmond Doyle
Who died at _____ on Aug 29 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex m Color or race B Single, ~~married~~, widowed or divorced: _____

Date of birth _____ Age: Years 61 Months 8 Days 28

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month Edmond Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) Specific heart disease
Birthplace of mother (State or country) by phlebotomy
Principal cause of death: _____

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician P. C. TURNER
Address of physician GENERAL HOSPITAL #2
Signature of Registrar M. M. Brown Date filed 9/30/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. _____
Primary Reg. Dist. No. _____
Very truly yours,
E. T. McGaugh M.D.
Special Agent.

S-29598

TO: SAC, NEW YORK
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

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