

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2623 Monroe ----- 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 56 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2623 Monroe Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4
year 1940 hour 11 minute 20 A.M.

21. I hereby certify that I attended the deceased from April 3, 1940, to April 4, 1940,
that I last saw him alive on April 4, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation
Duration _____

Due to Generalized myocardial insufficiency of coronary
Due to arteriosclerosis - 9301

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury M.D.
23. Signature Hubert A. Mack (M. D. or other) _____
Address 814 West 26th St Date signed 4-5-40

8. (a) PRINT FULL NAME Mr. Martin Boisen 250

3. (b) If veteran, name war None 8. (c) Social Security No. 100

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mrs. Alice Boisen 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 17 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 11 18 hr. _____ min.

9. Birthplace Copenhagen Denmark
(City, town, or county) (State or foreign country)

10. Usual occupation Lithographer

11. Industry or business American Can Company

12. Name Karl Boisen

13. Birthplace Denmark
(City, town, or county) (State or foreign county)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. May Anderson
(b) Address 2623 Monroe St.

17. (a) Burial (b) Date thereof April 6, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director M. M. Browe
(b) Address 1401 Brush Creek Blvd.

19. (a) April 5, 1940 (b) M. M. Browe
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Dr. Herbert M.
Med. Arts Bldg.
From - 2 - 5 0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed C. Hervey Cusenberry

Licensed Embalmer No. 40701

P. O. Address H. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.