V. S. No. 2
50M—5-42
5-17-39
P I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

5012

State File No.

FILED FEB 25 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 618

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: K.C. General Hospital No. 10
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 29 days (Specify whether
In this community 30 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson 3

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 309 Garfield
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Joseph J.B. Boes

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex ~~White~~ male

5. Color or race ~~White~~ 0

6. (a) Single, widowed, married, divorced 2 Wid

6. (b) Name of husband or wife Alice Boes

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Unknown (Month) — (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
about	87	0	0	hr. min.

9. Birthplace No Record 9
(City, town, or county) (State or foreign country)

10. Usual occupation Unknown

11. Industry or business

FATHER
12. Name No Record —
13. Birthplace No Record 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name No Record —
15. Birthplace No Record 9
(City, town, or county) (State or foreign country)

16. (a) Informant E. J. McBride (Exe. Estate)
(b) Address Union Nat Bank - K.C. Mo

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof Feb-8-1943 (Month) (Day) (Year)
(c) Place: burial or cremation Elmwood Cem

18. (a) Signature of funeral director Mrs C R Foster
(b) Address 918 Brooklyn

19. (a) 2-6-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. 4th day
year 1943 hour 5:00 P.M. minute M.

21. I hereby certify that I attended the deceased from 1-6-43, 19, to 2-4-43, 19;
that I last saw him alive on 2-4-43, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of left femur-accidental fall in home

Due to 18 hr

Due to 18

Other conditions Hypertensive heart diseas e
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None

Duration

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) Acc 123

(b) Date of occurrence

(c) Where did injury occur? K C. Jackson, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
(Specify type of place)

While at work? (e) Means of injury Fall

23. Signature Dwery R. Thom (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.