V. S. No. 2
0M—9-4-41
Rev. 5-17-39
PI X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

9202

State File No.

FILED MAR 31 1943

Local Registration District No. 49 Primary Registration District No. 1002 Registrar's No. 1458

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

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: 709 Washington /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 15 years.

2. USUAL RESIDENCE OF DECEASED: 48
(a) State Mo (b) County Jackson 3
(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL") 8
(d) Street No. 709 Washington
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Beryl Milburn
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex Femal
5. Color or race White
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May 11 1884 (Month) (Day) (Year)
8. AGE: Years 58 Months 10 Days 13 If less than one day hr. min.
9. Birthplace Ft Scott KS / (City, town, or county) (State or foreign country)
10. Usual occupation Sells newspapers
11. Industry or business
MOTHER FATHER
12. Name Wm Henry Boice
13. Birthplace Cross Road Ohio / (City, town, or county) (State or foreign country)
14. Maiden name Sara Elizabeth Winters
15. Birthplace Clarinda Iowa / (City, town, or county) (State or foreign country)
16. (a) Informant ~~Funeral office~~ Mrs Boice
(b) Address Pittsburg KS
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof March 25-43 (Month) (Day) (Year)
(c) Place: burial or cremation Pittsburg KS
18. (a) Signature of funeral director Parentis Bros.
(b) Address Kansas City Mo
19. (a) 3/25/43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24 year 1943 hour 8 minute P. M.
21. I hereby certify that I attended the deceased from ..... 19 ..... 19 ..... that I last saw him alive on ..... 19 ..... and that death occurred on the date and hour stated above.
Deputy Coroner

Immediate cause of death	Duration
Congenital deformity of back.	
Due to Congestive (obstructive) heart failure.	
Due to 93	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Inspection and history

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? (Specify type of place)
While at work (e) Means of injury
23. Signature H. E. Upper (M. D. or other)
Address 23 Ward Mo City Date signed 3/25/43

(Licensed Embalmer's Statement on Reverse Side)

#3

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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 Park G. Rowe

Licensed Embalmer No. 2347

P. O. Address K. 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, fact should be so stated above.