S. No. 2
OM—2-43
5-17-39
I X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 8 1949

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 20255

Registration District No. 749

Primary Registration District No. 1002

Registrar's No. 2849

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: 439 South Bellaire /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 42 Yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48 3

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

(d) Street No. 439 South Bellaire
(If rural, give location)

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

3. (a) PRINT FULL NAME Lawrence H. Boyle

3. (b) If veteran, name war None

3. (c) Social Security No. 707-10-5192

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married /

6. (b) Name of husband or wife Elizabeth Boyle

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased May 24 1880
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
63	1	0	hr. min.

9. Birthplace Atchison Kansas /
(City, town, or county) (State or foreign country)

10. Usual occupation Engineer (locomotive)

11. Industry or business Chicago Millw, Ry.

FATHER
12. Name Joseph Boyle
13. Birthplace Kansas /
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Emma Crawford
15. Birthplace Kansas /
(City, town, or county) (State or foreign country)

16. (a) Informant Elizabeth Boyle
(b) Address 439 South Bellaire

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Mt Moriah Cem.

18. (a) Signature of funeral director Mrs C. L. FORste
(b) Address KC mo.

19. (a) 6-26-43 (Date received local registrar) (b) T. E. Brown Dep. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24
year 1943 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from ____ 19__ to ____ 19__;
that I last saw h Deputy Coroner alive on ____ 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute & Chronic

Due to Myocardial infarction

Due to Coronary Occlusion

Other conditions
(Include pregnancy within 3 months of death)
94a

Major findings:
Of operations

Of autopsy See Above

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)

(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 A E Asher (M. D. or other) M.D.

Address 23rd McCoy Date signed 6/28/43

(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 Theron A. Redmon

Licensed Embalmer No. 2737

P. O. Address N.P. Me.

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.