

FILED APR 6 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

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: RESEARCH HOSPITAL  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 WEEKS  
(Specify whether years, months or days)  
 In this community 40 YEARS

3. (a) PRINT FULL NAME MR. FRANK BOREN  
 (b) If veteran, name war NO  
 (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED  
 (b) Name of husband or wife MRS. BLANCHE L. BOREN 6. (c) Age of husband or wife if alive 53 years  
 7. Birth date of deceased DECEMBER 21 1882  
(Month) (Day) (Year)

8. AGE: Years 61 Months 2 Days 20  
If less than one day hr. min.

9. Birthplace COUNCIL BLUFFS IOWA  
(City, town, or county) (State or foreign country)

10. Usual occupation GROCCER

11. Industry or business OWN BUSINESS-1300 WINCHESTER

MOTHER FATHER

12. Name MORGAN BOREN  
 13. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)  
 14. Maiden name LOUISE REBECCA BRANSON  
 15. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Blanche Boren  
 (b) Address 1300 Winchester

17. (a) BURIAL (b) Date thereof MARCH 13 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ELMWOOD CEMETERY

18. (a) Signature of funeral director O. N. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 3-13-44 (b) T. C. Brown  
(Date received local registrar) (Registrar's signature)

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. 1300 WINCHESTER AVENUE  
(If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 11<sup>TH</sup>  
 year 1944 hour 5 minute 20 P. M.  
 21. I hereby certify that I attended the deceased from Feb 14  
 1944 to March 11 1944  
 that I last saw him alive on March 11 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Brain tumor of temporo-parietal area 3 mos.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: Of operations none  
 Of autopsy Pending as to type  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (c) Accident, suicide, or homicide (specify) no  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? no  
(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) (M. D. or other)  
 M. D. or other \_\_\_\_\_

23. Signature Thomas M. Johnson M. D. or other \_\_\_\_\_  
 Address 1630 1/2 Broadway Date signed 11-13-44

151  
2  
Professional Bill

**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 *A. C. M.*

Licensed Embalmer No. *4043*

P. O. Address *A. C. M.*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1148

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Frank Boren

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

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

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

8. AGE: Years Months Days If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 5-3-44 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH: Month mar day 11  
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19....., and that death occurred on the date and hour stated above. Immediate cause of death.....

Due to Highly malignant hemorrhagic, necrotic spongioblastoma  
Due to multiforme of right cerebrum  
Other conditions..... (include pregnancy within 3 months of death)  
Major findings:  
Of operations.....  
Of autopsy.....

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.....

23. Signature..... (M. D. or other).....  
Address..... Date signed.....

SUPPLEMENTARY

Brain tumor

548

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

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

91683