

**FILED** JAN 24 1946

Registration District No. 177 Primary Registration District No. 1002

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:  
General Hospital #2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 23 days  
(Specify whether 35 yrs)

In this community 35 yrs  
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. 1119 1/2 W. 24th St.  
(If rural, give location)

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

3. (a) PRINT FULL NAME Malinda Boles

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife Thomas Boles

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased April 29 1910  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>35</u>	<u>7</u>	<u>27</u>	hr. _____ min.

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

10. Usual occupation Office Girl

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Silas Reed

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

14. Maiden name Ava Horn

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

16. (a) Informant Medical Records Librarian

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 12/31/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highlands Cem.

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

(b) Address 1729 Lydia

19. (a) 12-29-45 (b) Malindine Holms  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 26,  
year 1945 hour 5: minute 48 A. M.

21. I hereby certify that I attended the deceased from December  
3, 1945, to December 26, 1945;

that I last saw her alive on December 26, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations 33K

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)

Means of injury D

23. Signature [Signature] (M. D. or other)  
Address General Hospital #2 Date signed 12/26/45

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

100233 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

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.**