

FILED OCT 14 1947

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

Primary Registration District No. 3000

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

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirkville  
(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 of location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

In this community 32 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair

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

(d) Street No. 501 E. Randolph  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES BOYLAND

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Mary M. Boyland

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

7. Birth date of deceased: March 10, 1847  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>106</u>	<u>6</u>	<u>23</u>	hr. min.

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

10. Usual occupation Maulder

11. Industry or business Die Casting

12. Name Patrick Boyland

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

14. Maiden name Anties Campbell

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

16. (a) Informant James Boyland

(b) Address Kirkville, Mo.

17. (a) Burial (b) Date thereof 10-5-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Thomas Union Prot

18. (a) Signature of funeral director Thomas Union Prot

(b) Address Kirkville, Mo.

19. (a) 10-11-47 (b) State Lambert  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3  
year 1947 hour 5 minute 15 A.M.

21. I hereby certify that I attended the deceased from Sept 1,  
1947 to Oct 6, 1947  
that I last saw him alive on Oct 3, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy, cerebral

Due to hypertension

arterio sclerosis

Due to Changes of extreme age  
(106)

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

Duration

sync.  
10 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: Of operations 831

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 J. King (M. D. or other) MD  
Address Kirkville Mo Date signed 10-3-47

RECEIVED  
District Health Officer No. 10  
District File Number 10-47-141  
OCT 13 1947  
Date filed

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

*Lawrence M. Billo*

Licensed Embalmer No.

4375

P. O. Address

*Kirkville, 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.