

FILED JUL 1 1950 STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2598

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE KANSAS b. COUNTY ANDERSON	
b. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) COLONY 9150	
c. LENGTH OF STAY (In this place) 2 wks		d. STREET ADDRESS (If rural, give location) 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION OSTEOPATHIC HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) STEPHEN b. (Middle) BETHEL c. (Last) BOONE			4. DATE OF DEATH (Month) (Day) (Year) JUNE-11-1950		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 1	
8. DATE OF BIRTH OCT-29-1873		9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME DANIEL BOONE		13b. MOTHER'S MAIDEN NAME AMANDE CRAB		14. NAME OF HUSBAND OR WIFE OMIE BOONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. T		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. OMIE BOONE COLONY KANSAS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hemorrhage from bladder. DUE TO (c) Prostatic Hypertrophy		INTERVAL BETWEEN ONSET AND DEATH 8 hours 1 week unknown	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				610X	

19a. DATE OF OPERATION 6-5-50		19b. MAJOR FINDINGS OF OPERATION Hypertrophied Prostate with Bladder Hemorrhage		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **May 29, 1950**, to **June 11, 1950** that I last saw the deceased alive on **June 11, 1950** and that death occurred at **9:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE John G. Henry (Degree or title)		23b. ADDRESS 500 Bryan Bldg. K.C.M.		23c. DATE SIGNED 6-12-50	
24a. BURIAL, CREMATION (Specify)		24b. DATE JUNE-12-1950		24c. NAME OF CEMETERY OR CREMATORY -	
24d. LOCATION (City, town, or county) (State) COLONY, KANSAS					

DATE REC'D BY LOCAL REG. 6-12-50		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS D.W. Newcomer 1331 BRUSH DREXEL BLVD KANSAS CITY, MO.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Robert Ray

Signed.....

Student Embalmer

Licensed Embalmer No. *4182*

P. O. Address *Kansas City*

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.