

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17908

State File No. _____

FILED MAY 27 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2413

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this place) <u>4 YEARS</u>	c. CITY OR TOWN <u>KANSAS CITY</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>RESEARCH HOSPITAL</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		STREET ADDRESS (If rural, give location) <u>710 5225 Brookwood K Mo</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>HOWARD</u> b. (Middle) <u>R.</u> c. (Last) <u>Boicourt</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 9 1953</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 6, 1897</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK WATSON BROS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRANSFER CO</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>ELIHU Boicourt</u>	13b. MOTHER'S MAIDEN NAME <u>MARY MOWL</u>	14. NAME OF HUSBAND OR WIFE <u>ALICE Boicourt</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>490-34-1564</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS. ALICE Boicourt</u>	ADDRESS <u>5225 Brookwood K.C.</u>
--	--	--	------------------------------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain tumor, left frontal, malignant.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>✓</u>		
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>1937</u>

19a. DATE OF OPERATION <u>5-8-53</u>	19b. MAJOR FINDINGS OF OPERATION <u>Biopsy - Encephalomalacia and tumor</u>	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) _____	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 4-2-53, 1953, to 5-9-53, 1953, that I last saw the deceased alive on 5-8-, 1953 and that death occurred at 7:15 Am., from the causes and on the date stated above.

23a. SIGNATURE <u>Frank R. Teicher</u> (Degree or Title) <u>MD</u>	23b. ADDRESS <u>411 Nichols Road K. C. Mo.</u>	23c. DATE SIGNED <u>5-11-53</u>
--	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>MAY 11, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
---	-------------------------------	---	---

DATE REC'D BY LOCAL REG. <u>5-11-53</u>	REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>A. W. Newcomer's Sons</u>	ADDRESS <u>1301 South Linden Kansas City, Mo.</u>
---	--	---	---

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Charles H. Strickman*.....

Licensed Embalmer No. *456*.....

P. O. Address *100 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.