

FILED MAY 4 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13149

BIRTH NO. 02342656 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1636

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Shawnee	
c. LENGTH OF STAY (In this place) 1 day		d. STREET ADDRESS (If rural, give location) 13315 Johnson Dr. 715 3	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital			
3. NAME OF DECEASED a. (First) Timothy b. (Middle) Jackson c. (Last) Boyd		4. DATE OF DEATH (Month) (Day) (Year) April 14, 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Baby	8. DATE OF BIRTH 4-13-1956
9. AGE (In years last birthday) 0		10. MONTHS 0	11. DAYS 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Kansas City, Missouri
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Woodrow Jackson Boyd		13b. MOTHER'S MAIDEN NAME Nancy Sue Mc Cullough	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Woodrow Jackson Boyd
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 Hyaline Membrane ANTECEDENT CAUSES Prematurity Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) m.	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 Apr. 13, 1956, to Apr. 14, 1956, that I last saw the deceased alive on Apr. 14, 1956, and that death occurred at 6:40 pm from the causes and on the date stated above.			
23a. SIGNATURE Paul B. Burger (Degree or title) M.D.		23b. ADDRESS 5949 Neuman Rd - Shawnee, Ks	23c. DATE SIGNED 4-15-56
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-16-56	24c. NAME OF CEMETERY OR CREMATORY Pleasant View Cem.	24d. LOCATION (City, town, or county) (State) Shawnee, Kansas
DATE REC'D BY LOCAL REG. 4-15-56	REGISTRAR'S SIGNATURE neva minshall	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. Paul Amos Shawnee, Kansas	

(Licensed Embalmer's Statement on Reverse Side)

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

Student Embalmer

Signed.....

E. Paul Amos

Licensed Embalmer No. *4385*

P. O. Address *Shawnee, Kan*

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.