

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16956

STATE FILE NUMBER

FILED JUN 12 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2454

300
1-57

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| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hospital | | Length of stay in lb 50 yrs. | d. STREET ADDRESS 2901 Charlotte (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First HAZEL Middle T. Last BOYLE | | | 4. DATE OF DEATH Month May Day 26 Year 1957 |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 18, 1892 |
| 9. AGE (In years last birthday) 64 | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Kansas City, Kansas |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME John McCormick | 13b. MOTHER'S MAIDEN NAME Unknown |
| 14. NAME OF HUSBAND OR WIFE John P. Boyle—Deceased | | 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. NONE |
| 17. INFORMANT Thomas W. Boyle—8701 E. 114th Terr. Mills, Mo. | | Address Hickman | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis | | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio-sclerotic heart disease | | | years |
| DUE TO (c) ? | | | 4200 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Partial intestinal obstruction due to adhesion bands | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____ | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
| 21. I attended the deceased from March 27, 1955 May 26, 1957 and last saw her alive on May 25, 1957 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Robert Jansen, M.D. (Degree or title) | | 22b. ADDRESS 101 E 63rd St. | 22c. DATE SIGNED 5-27-57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 5/29/57 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri |
| 24. FUNERAL DIRECTOR QUIRK & TOBIN-20 W. Linwood, K.C. Mo. | | 25. DATE RECD. BY LOCAL REG. 5-27-57 | 26. REGISTRAR'S SIGNATURE Neva Minshall |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Robert Jansen



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 *Forrest D. Caldwell*

Licensed Embalmer No. *4714*

P. O. Address *K. C. 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.