

Health, Welfare Public Service

FILED SEP 24 1957

STANDARD CERTIFICATE OF DEATH

31791
STATE FILE NUMBER 4130

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 4130

300
1-57

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 (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys Hosp.</u>		Length of stay in lb <u>2 wks.</u>	d. STREET ADDRESS (If outside, give location) <u>3143 Bell</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>William John Bovell</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>2</u> Year <u>1957</u>	
First <u>William</u> Middle <u>John</u> Last <u>Bovell</u>				

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13 1870</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal</u>	11. BIRTHPLACE (City and state or country) <u>Abington Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>William Cubine</u>	13b. MOTHER'S MAIDEN NAME <u>Annie Grimsley</u>	14. NAME OF HUSBAND OR WIFE <u>Lena Cubinee</u>
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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>None</u>	17. INFORMANT <u>Lena Cubinee</u> Address <u>3143 Bell</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal bronchopneumonia</u> <u>Cerebral arteriosclerosis with</u> <u>thrombosis and apoplexy</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Senility</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>332X</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a.m. <u> </u> p.m. <u> </u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	20f. COUNTY	20g. STATE
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21. I attended the deceased from <u>1942</u> to <u>9-2-57</u> and last saw him <u>XXXX</u> alive on <u>9-2-57</u> Death occurred at <u> </u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Neva Marshall</u> (Degree or title) <u>0</u>	22b. ADDRESS <u>1420 So. 42nd St. - K.C.K.</u>	22c. DATE SIGNED <u>9-3-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/4/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>
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24. FUNERAL DIRECTOR <u>Gates Funeral Home</u> ADDRESS <u>K C Kan</u>	25. DATE RECD. BY LOCAL REG. <u>9-4-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

G.P. Neighbor

All diseases in Part I must be causally related.

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 *Paul R. Williamson*

Licensed Embalmer No. *5009*
P. O. Address *Overland Park, Kansas*

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.