

FILED OCT 11 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32293

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 419

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) TOWN INDEPENDENCE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN LEE'S SUMMIT MO
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION INDEP. SANITARIUM		Length of stay in lb 1 WEEK	d. STREET ADDRESS (If outside, give location) 828 LAKE LOTOWANA
3. NAME OF DECEASED (Type or print) First Middle Last LEE CONRAD HORN BOSTEL			4. DATE OF DEATH Month Day Year SEPT. 25 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN-16, 1880
9. AGE (In years last birthday) 77		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) RETIRED - BIR'S SANITARIUM		10b. KIND OF BUSINESS OR INDUSTRY BAGGAGE & EXPRESS	11. BIRTHPLACE (City and state or country) SPRINGFIELD MISSOURI
13a. FATHER'S NAME AUGUST HORN BOSTEL		13b. MOTHER'S MAIDEN NAME ANNA GOTTFRIED	12. CITIZEN OF WHAT COUNTRY? U. S. A.
14. NAME OF HUSBAND OR WIFE CATHERINE HORN BOSTEL		17. INFORMANT Address LAKE LOTOWANA MRS. CATHERINE HORN BOSTEL LEE'S SUMMIT MO	
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. 712-14-9327	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized debility - unruptured aneurysm			INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
DUE TO (b) Carcinomatosis, diffuse			2 yrs.
DUE TO (c) Primary cancer of brain			3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			1551
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 WORK <input type="checkbox"/> NOT WHILE 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 August 31, 57 to Sept 25, 57 and last saw him alive on Sept. 25, 1957 Death occurred at 7:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert H. Quilley, M.D.		22b. ADDRESS Raytown, Mo	22c. DATE SIGNED 9/26/57
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 9-26-57	23c. NAME OF CEMETERY OR CREMATORY St. MARY'S	23d. LOCATION (City, town, or county) (State) SPRINGFIELD MISSOURI
24. FUNERAL DIRECTOR ADDRESS D.W. NEWCOMER'S SONS		25. DATE RECD. BY LOCAL REG. 9-26-57	26. REGISTRAR'S SIGNATURE [Signature]

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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 *Adrian Jay Stett*

Licensed Embalmer No. *4882*

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.