

Health, Welfare, Public Service

FILED FEB 24 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005374

STATE FILE NUMBER

497

Registration District No. 149

Primary Registration District No. 1002

Registrar No.

1. PLACE OF DEATH

a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Mo. b. COUNTY Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Inside Limits Yes No

c. CITY OR TOWN Kansas City
Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Little Sisters Home 23 years
Length of stay in lb

d. STREET ADDRESS (If outside, give location) 5331 Highland Ave.
Reside on Farm Yes No

3. NAME OF DECEASED (Type or print)

First Middle Last
Miss Ada Ruth Boyle

4. DATE OF DEATH
Month Day Year
Jan. 28, 1958

5. SEX Female

6. COLOR OR RACE White

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH
Sept. 2, 1869

9. AGE (In years) 88 years
IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)
Olathe, Mo.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13a. FATHER'S NAME
No record

13b. MOTHER'S MAIDEN NAME
No record

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
No No

16. SOCIAL SECURITY NO.
None

17. INFORMANT Address
Mother Lawrence, Little Sisters Home

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Broncho-pneumonia (Hypostatic)

INTERVAL BETWEEN ONSET AND DEATH
3 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

Arterio-sclerosis

20 yrs

DUE TO (c)

45 yrs

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 NO

20a. ACCIDENT SUICIDE HOMICIDE

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 NOT WHILE AT WORK

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 3/17/50 to 1/28/58 and last saw her alive on 1/27/58
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Death or title) Joseph A. Fogarty MD

22b. ADDRESS 5811 Truman Rd. K.C. Mo.

22c. DATE SIGNED 1/30/58

23a. BYRRAL, CREMATION, REMOVAL (Specify)

23b. DATE Feb. 1, 1958

23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery

23d. LOCATION (City, town, or county) (State)
Hickman Mills, Mo.

24. GENERAL DIRECTOR ADDRESS
Thomas W. Quirk 4316 Troost Ave.

25. DATE RECD. BY LOCAL REG. 1-31-58

26. REGISTRAR'S SIGNATURE
Neve Marshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Joseph A. Fogarty



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 *Thomas Lewis*

Licensed Embalmer No. 337 P. O. Address

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.