

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001212

STATE FILE NUMBER
62

Registration District No. 149 Primary Registration District No. 1002 Registration No. _____

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>JOHNSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>MISSION</u> ^{715⁶} ₈
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARY'S HOSPITAL</u>		Length of stay in 1b <u>1-DAY</u>	d. STREET ADDRESS (If outside, give location) <u>5400 SYCAMORE DRIVE</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>ELLSWORTH</u> Last <u>BOYLE</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>5</u> Year <u>1959</u>			
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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 2 - 1890</u>	9. AGE (In years last birthday) <u>68</u>	FUNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>CHIEF SPECIAL AGENT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>ROCK ISLAND R.R.</u>	11. BIRTHPLACE (City and state or country) <u>HARDIN, OHIO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
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13a. FATHER'S NAME <u>SAMUEL BOYLE</u>	13b. MOTHER'S MAIDEN NAME <u>JANE LIPPOTH</u>	14. NAME OF HUSBAND OR WIFE <u>MRS. ANNA BOYLE</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>YES 1907-1911</u>	16. SOCIAL SECURITY NO. <u>707-16-8593</u>	17. INFORMANT <u>MRS. ANNA BOYLE</u> Address <u>5400 SYCAMORE DRIVE MISSION KANSAS</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>Pyonephritis Bilateral Rt. lung.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks -</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive Cardiovascular Disease</u>		<u>2 yrs -</u>
	DUE TO (c) <u>Hemiplegia Left Side - 4 1/2 yr</u>		<u>1 yr -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral accident vascular (1 yr ago)</u>		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.) <u>none with last illness.</u>
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20c. TIME OF INJURY Hour _____ 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
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21. I attended the deceased from <u>June 1948</u> to <u>1-5-59</u> and last saw her alive on <u>1-5-59</u> Death occurred at <u>6:45</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>James W. Downey M.D.</u> (Degree or title)	22b. ADDRESS <u>425 E 63rd K.C. Mo.</u>	22c. DATE SIGNED <u>1/6/59</u>

23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>JAN. 7 - 1959</u>	<u>MT. CALVARY CEMETERY</u>	<u>KANSAS CITY KANSAS</u>

24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u> ADDRESS <u>1331 BRUSH CREEK KANSAS CITY MO.</u>	25. DATE RECD. BY LOCAL REG. <u>1-6-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

300
-57

James W. Downey
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

SEP 3 1959



6961 I & 707 EA
JUL 31 1959

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 *Albert L. Savage*

Licensed Embalmer No. *4812*

P. O. Address *Kansas City*

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.