

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013184

STATE FILE NUMBER

FILED APR 20 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1667

Health, Welfare, Public Service
300
-57
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.
J. W. YOUNG

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) OR TOWN <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>3544 WABASH</u>		Length of stay in lb <u>2 years</u>	d. STREET ADDRESS (If outside, give location) <u>3544 WABASH</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>A.</u> Last <u>Boyle</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>31</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 11, 1873</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9c. AGE (In years last birthday) <u>86</u> 10. FUNDING YEAR Months <u>86</u> Days <u></u> Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>MOUNT STEERING ILLINOIS U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Andrew Wagner</u>		13b. MOTHER'S MAIDEN NAME <u>KATHRYN GREYER</u>	14. NAME OF HUSBAND OR WIFE <u>Henry Boyle (deceased)</u>
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 Address <u>Henry Boyle 3544 WABASH</u>
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>Hypostatic Br. Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) <u>9040</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 checked="" 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>Fractured Rt. Femur on 3/8/59, fall</u>		
20c. TIME OF INJURY Hour _____ a.m. <u>3-8</u> p.m. <u>59</u>	20d. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <u>Home</u>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>K.C. 123</u>	COUNTY <u>Jackson</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>3/8/59</u> to <u>3/31/59</u> and last saw her alive on <u>3/31/59</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. W. Young M.D.</u> (Degree or title)		22b. ADDRESS <u>1401 S. W. Blvd. K.C.K.</u>	22c. DATE SIGNED <u>4/1/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>April 2, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Burlington, Kansas</u>
24. FUNERAL DIRECTOR <u>Muehlebach</u>		ADDRESS <u>6800 TROOST</u>	25. DATE RECD. BY LOCAL REG. <u>4-2-59</u>
26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>			

1401 S. W. Jones

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 *J. T. Cromell*

Licensed Embalmer No. *4904*

P. O. Address *H. E. Ma*

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.