

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS SEP 23 1959**

**59-032237**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4324 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>60 yrs</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR <b>NORTHEAST REST HOME</b> INSTITUTION <b>3240 NORLEDGE</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1101 EAST 11th STREET</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>LEAH BOYD</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>5</b> Year <b>1959</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 13, 1875</b>	9. AGE (last birthday) <b>84 yrs</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ATCHISON KANSAS</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>WILLIAM GREITZ</b>			13b. MOTHER'S MAIDEN NAME <b>REBECCA LUTZ</b>			14. NAME OF HUSBAND OR WIFE <b>EDWIN D. BOYD</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO.</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS W. T. BLACKWELL HOTEL MUEHLERBACH</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Artery Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Artery Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								INTERVAL BETWEEN ONSET AND DEATH <b>20 h</b>	
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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____									
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 <b>Pharro City Jackson Mo.</b>		COUNTY		STATE	
21. I attended the deceased from <b>May 1959</b> to <b>Sept. 4, 1959</b> and last saw her alive on <b>Sept 3, 1959</b> Death occurred at <b>11:55 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>K. L. Shireman M.D.</b> (Degree or title)				22b. ADDRESS <b>4606 St John KC Mo</b>				22c. DATE SIGNED <b>9-6-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>SEPT 7, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. VERNON CEM</b>			23d. LOCATION (City, town, or county) (State) <b>ATCHINSON KANSAS</b>			
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS, 1331 BRUSH CREEK BLVD. ADDRESS KANSAS CITY, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>9-7-59</b>		26. REGISTRAR'S SIGNATURE <b>neva minshall</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF K. Shireman

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Vern Lawler*

Licensed Embalmer No. 4915

P. O. Address AC 70

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.