

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032238

FILED VS SEP 23 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4342 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b Life		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6200 Rockhill Rd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) William B. Boyle				4. DATE OF DEATH Month 9 Day 7 Year 59									
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 6-10-1911		9. AGE (last birthday) 48		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (21 years)				10b. KIND OF BUSINESS OR INDUSTRY Country Club P.O.		11. BIRTHPLACE (City and state or country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY U. S. A.					
13a. FATHER'S NAME Patrick W. Boyle			13b. MOTHER'S MAIDEN NAME Anna Jane Arma Jane Stone			14. NAME OF HUSBAND OR WIFE Helen L. Boyle							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No none			16. SOCIAL SECURITY NO. 496-05-1543			17. INFORMANT Address Mrs. Helen Boyle 6200 Rockhill Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION										INTERVAL BETWEEN ONSET AND DEATH 30 MIN.			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) HYPERTENSION, E.S.										YES			
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 d. s. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
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 15.)									
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		COUNTY		STATE			
21. I attended the deceased from 1948 to 9-7-59 and last saw ^{her} him alive on 9-7-59 Death occurred at 11:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) B. Marcus Heller M.D.						22b. ADDRESS 409 E. 63-d			22c. DATE SIGNED 9-7-59				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-9-1959		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery			23d. LOCATION (City, town, or county) (State) Kansas City, Missouri						
24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eylar Linwood				25. DATE RECD. BY LOCAL REG. 9-8-59		26. REGISTRAR'S SIGNATURE Neva Marshall							

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DOCUMENT

BY AFFIDAVIT OF Informant
MEDICAL CERTIFICATION
B. MARCUS HELLER

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 Melvin Bartel

Licensed Embalmer No. 4903

P. O. Address KC 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.