

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-001401

FILED VS FEB 15 1960

593

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 593

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>mt Kansas City</u>		Length of stay in 1b <u>45 yrs</u>		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>3736 Garfield</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3736 Garfield</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>H.</u> Last <u>BOLAND</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1960</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</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>3-26-1888</u>		9. AGE (last birthday) <u>71</u>					
IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Co. Midwest Envelope</u>		11. BIRTHPLACE (City and state or country) <u>Fayetteville, Ark.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Wm. Harris</u>				13b. MOTHER'S MAIDEN NAME <u>Loudora Webb</u>				14. NAME OF HUSBAND OR WIFE <u>Wm. Joseph Boland</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>486-01-5177</u>		17. INFORMANT <u>Mrs. Catherine Koch, 3736 Garfield</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>										Years.			
DUE TO (b) <u>Arteriosclerotic heart disease</u>										Years.			
DUE TO (c) <u>Generalized arteriosclerosis</u>										Years.			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										PART III. If deceased was female was there a pregnancy in last 90 days.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary fibrosis</u>										<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input 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.)									
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 <u>2/26/52</u> to <u>2/2/60</u> and last saw <u>her</u> <input checked="" type="checkbox"/> alive on <u>February 2, 1960</u>										Death occurred at <u>10:40 A. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Doctor or title) <u>W. A. Stentz, M.D.</u>					22b. ADDRESS <u>4620 Nichols Pkwy., K. C., Mo.</u>			22c. DATE SIGNED <u>2/2/60</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-4-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>						
24. FUNERAL DIRECTOR <u>Mellody-McGilley-Eylar Funeral Home</u>				ADDRESS <u>Woodland-Linwood</u>		25. DATE RECD. BY LOCAL REG. <u>2-2-60</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

J. W. A. S.

4620 Nichols

LO 1-3500

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Melvin Bart

Licensed Embalmer No. 498

P. O. Address R C M

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.