

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006163

FILED VS. MAR 11 1960 149

Primary Registration District No. 1002 Registrar's No. 1190

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 22 yrs.	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3800 MERCIER		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3800 MERCIER Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last HENRY MONROE BOSTON			4. DATE OF DEATH Month Day Year 2 25 60				
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 SEPT 20, 1894	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) R. R. SWITCHMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) PUEBLO, COLO.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME WILLIAM BOSTON			13b. MOTHER'S MAIDEN NAME LILLIAN SHIVELY		14. NAME OF HUSBAND OR WIFE JEAN R BOSTON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 703 03 9583		17. INFORMANT Address JEAN BOSTON 3800 MERCIER		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon <i>extending into peritoneum, pelvis and bladder. Exploratory operation 1-8-60 tumor not removable so colostomy done</i>			INTERVAL BETWEEN ONSET AND DEATH 7 mo?		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) marked obesity DUE TO (c) marked obesity			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		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If no terminal disease condition given in PART I (a))					

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.) none			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. none	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.) none	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE

21. I attended the deceased from **12-3-59** to **2-25-60** and last saw him alive on **2-24-60**
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Harvey Jennett, M.D.		22b. ADDRESS 1500 Professional Bldg Kansas City 6 Mo		22c. DATE SIGNED 2-26-60
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2 29 60	23c. NAME OF CEMETERY OR CREMATORY FLORAL HILLS CEM	23d. LOCATION (City, town, or county) (State) KANSAS CITY MO.	

24. FUNERAL DIRECTOR D W NEWCOMER'S SONS KC. MO.	ADDRESS	25. DATE RECD. BY LOCAL REG. 2-29-60	26. REGISTRAR'S SIGNATURE Neva Marshall
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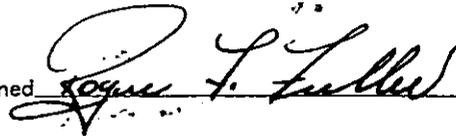
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
Harvey Jennett

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



Licensed Embalmer No. 4818

P. O. Address K. C. 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.