

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046453

FILED VS JAN 4 1961

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 10

STATE FILE NUMBER

DED

|   |  |   |  |  |  |  |   |         |  |
|---|--|---|--|--|--|--|---|---------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> |  |  |   |         |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>INDEPENDENCE</b>   |  | Length of stay in 1b<br><b>62 yrs.</b>  |  | c. CITY OR TOWN <b>INDEPENDENCE</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |         |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>D.O.A. INDEP. SAN. &amp; HOSP.</b>  |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)<br><b>709 No. Delaware</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |         |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>LAWRENCE</b> Middle <b>A.</b> Last <b>BOSTIAN</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>28</b> Year <b>1960</b>   |  |  |   |         |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8-31-1898</b>   | 9. AGE (last birthday)<br><b>62</b>                                      | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 24 HR<br>Hours _____ Min. _____  |         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SELF-EMPLOYED</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>INSURANCE BUSINESS</b>                       |  | 11. BIRTHPLACE (City and state or country)<br><b>INDEPENDENCE, MO.</b>   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |         |  |
| 13a. FATHER'S NAME<br><b>WILLIAM BOSTIAN</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>MARGARET HINTERS</b>                                 |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>MARGUERITE M. BOSTIAN</b>  |   |         |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NBS WW I</b>  |  | 16. SOCIAL SECURITY NO.<br><b>490-09-0653</b>   |  | 17. INFORMANT<br><b>Marguerite M. Bostian, 709 No. Delaware, Indep</b>   |  |  |   | Address |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion - sub</b><br><b>arterial Hypertension</b><br><b>Diabetes Mellitus</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b><br><b>2 yrs</b>   |   |         |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |         |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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 _____, to _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |  |  |  |  |   |         |  |
| 22a. SIGNATURE<br><b>Fredrick Hink M.D.</b> (Degree or title)   |  |   |  | 22b. ADDRESS<br><b>10 229 Independence KE 22 No</b>  |  |  | 22c. DATE SIGNED<br><b>12/28/60</b>   |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>12-31-60</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. MARY'S CEMETERY</b>                     |  |  | 23d. LOCATION (City, town, or county) (State)<br><b>INDEPENDENCE, MISSOURI</b>   |   |         |  |
| 24. FUNERAL DIRECTOR<br><b>GEO. C. CARSON &amp; SONS, INDEPENDENCE, MO.</b>   |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>12-31-60</b>                                      |  | 26. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                          |  |   |         |  |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 10 1961

JAN 17 1961

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed Hal Thoenberg

Licensed Embalmer No. 340

P. O. Address. Indep. M

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