

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-025048

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3212

STATE FILE NUMBER

FILED JUL 17 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b Sudden	c. CITY OR TOWN Mission Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION In an ambulance		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5143 Maple Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First CLARENCE Middle JOSEPH Last BOYLE	4. DATE OF DEATH Month June Day 27 Year 1961
---	--

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 4-3-1904	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months 57 Days 0 Hours 0 Min. 0	IF UNDER 24 HR Hours 0 Min. 0
-----------------------	----------------------------------	---	-------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stereotyper	10b. KIND OF BUSINESS OR INDUSTRY Newspaper	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY USA
---	---	---	---

13a. FATHER'S NAME Lawrence J. Boyle	13b. MOTHER'S MAIDEN NAME Elizabeth Flaschbarth	14. NAME OF HUSBAND OR WIFE Marie C. Boyle
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	17. INFORMANT Mrs. Marie Boyle Address Mission, Kansas
---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis and Venous Thrombosis DUE TO (b) Coronary Thrombosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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"/> N. <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 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 Feb 1961 to June 27, 1961 and last saw her alive on June '61 Death occurred at 9:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul T. McDaniel MD	22b. ADDRESS 920 West 47th St.	22c. DATE SIGNED 6-27-61
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-27-1961	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	23d. LOCATION (City, town, or county) Kansas City, Kansas	(State)
---	-------------------------------	---	---	---------

24. FUNERAL DIRECTOR E. Paul Amos	ADDRESS Shawnee, Kansas	25. DATE RECD. BY LOCAL REG. 6-28-61	26. REGISTRAR'S SIGNATURE Ruth Long
---	-----------------------------------	--	---

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

PULL TO MC CARTON

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Eugene P. Amos
Eugene P. Amos

Licensed Embalmer No. 5023

P. O. Address Shawnee, Kansas

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.