

No. 2
1-4-41
-17-39
X26390

FILED AUG 16 1941
Registration District No.

Primary Registration District No. 1002

Registrar's No. 2622

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 23 days
In this community 8 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 1749
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 637 Garfield 9
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 11th day
year 1941 hour 7 minute 45 A. M.
21. I hereby certify that I attended the deceased from 6-18-41, 19... to 7-11-41, 19...
that I last saw him alive on 7-11-41, 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary sclerosis;
acute pulmonary edema; cystitis, pyelo-
nephritis. Duration

Due to Post operative prostatectomy for
benign prostatic hypertrophy ✓

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

1378

Of autopsy See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME James H. Boyd

3. (b) If veteran, name war 720 3. (c) Social Security No. No

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Martha 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased July 18 69
(Month) (Day) (Year)

8. AGE: Years 72 Months - Days - If less than one day min.

9. Birthplace Kewanee Ill
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business

12. Name Henry Boyd

13. Birthplace England 4
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Jane Wolf

15. Birthplace Kansas 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. John Parsons

(b) Address 637 Garfield

17. (a) Buried (b) Date thereof 7-13-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Humboldt

18. (a) Signature of funeral director Sheel Funeral Home
(b) Address Kansas City Mo

19. (a) 7-12-41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature Wm. R. Koon (M. D. or other) D
Address Med. Dir. K.C. Gen. Hospital Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

48
836

94W

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24083
Registrar's No. 2627

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town N.C.
(c) Name of hospital or institution:
San Diego
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME James H. Boyd
3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 72 Months _____ Days _____ If less than one day _____ min.

9. Birthplace (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Nov 27 41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH: Month July day 11 - 1941
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Cor. Sclerosis
acute prostatic cystitis - pyelonephritis
Due to _____

The to: P. D. Prostatectomy for benign hyperplasia
Other conditions (include pregnancy within 3 months of death) _____

Major findings: 6/25/41
Of operations _____
Of autopsy 137a

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) _____
While at work? _____ (e) Means of Injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

18
23
28

