

**FILED JUN 7 1943**

Registration District No. **149**

Primary Registration District No. **1002**

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: **Lake Side Hospital 29th & Florida**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **25 days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Carroll**  
(c) City or town **Bogard** (If outside city or town limits, write "RURAL")  
(d) Street No. **1** (If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **LEE ROY BOULWARE**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **MO** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **Elyabeth Boulware** 6. (c) Age of husband or wife if alive **63** years  
7. Birth date of deceased **Apr - 5 - 1873**  
(Month) (Day) (Year)

8. AGE: Years **70** Months **1** Days **22** If less than one day hr. min.

9. Birthplace **Saline Co Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business.....

MOTHER FATHER { 12. Name **Thomas H Boulware**  
13. Birthplace **Virginia** (City, town, or county) (State or foreign country)  
14. Maiden name **unknown**  
15. Birthplace **unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Paul Boulware**

(b) Address **N.E. MO 1330 E 45th**

17. (a) (Burial, cremation, or removal) (b) Date thereof **5-30-43**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **Union Cem, Saline Co Mo**

18. (a) Signature of funeral director **Harry Hensinger**  
(b) Address **Marshall Mo**

19. (a) **5-27-43** (b) **M. M. Brown**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **27** day **May**  
year **1943** hour **8** minute **A** M.

21. I hereby certify that I attended the deceased from **May 3rd** 19**43** to **5-27** 19**43**  
that I last saw her alive on **5-26** 19**43**  
and that death occurred on the date and hour stated above.

Immediate cause of death **EMBOLISM Causing A few Coronary Occlusions**  
Due to **Adenocarcinoma of Prostate**  
Due to **SIB**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Enlarged Prostate**  
Of operations **Adenocarcinoma**  
Of autopsy.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?

While at work? (Specify type of place) (f) Means of injury.....

23. Signature **L. J. Graham** (M. D. or other) **MO**  
Address **811 Chamber Bldg** Date signed **5-27**

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

**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.**