

FEDERAL BUREAU OF INVESTIGATION
STANDARD CERTIFICATE OF DEATH

FILED DEC 29 1948, 49
Registration District No. _____

Primary Registration District No. **1002**

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

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 **GENERAL HOSPITAL # 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 das, 19 hrs, 43 mins**
In this community **20 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **JACKSON**
(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")
(d) Street No. **3524 COLORADO**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME **ELLEN BOSTIC**
3: (b) If veteran, name war **NO**
3: (c) Social Security No. **NONE**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **DECEMBER** day **14th**
year **1948** hour **3:10** minute **A.** M.
21. I hereby certify that I attended the deceased from **DECEMBER 11th**, 19 **48** to **DECEMBER 14th**, 19 **48**
that I last saw h **er** alive on **DECEMBER 14th**, 19 **48**
and that death occurred on the date and hour stated above.

4. Sex **3 FEMALE**
5. Color or race **NEGRO**
6: (a) Single, widowed, married, divorced **MARRIED**
6: (b) Name of husband or wife **THOMAS BOSTIC**
6: (c) Age of husband or wife if alive **unknown** years
7. Birth date of deceased **MARCH 22 1876**
(Month) (Day) (Year)

Immediate cause of death
ARTERIOLAR NEPHROSCLEROSIS
HYPERTENSION (CLINICAL)
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years **72** Months **8** Days **22** If less than one day _____ hr. _____ min.
9. Birthplace **LOUISVILLE, KENTUCKY**
(City, town, or county) (State or foreign country)

Major findings: **1312**
Of operations _____
Of autopsy **SAME AS ABOVE**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOYER FATHER

11. Industry or business _____
12. Name **JAMES STONE**
13. Birthplace **NOT KNOWN**
(City, town, or county) (State or foreign country)
14. Maiden name **CAROLINE**
15. Birthplace **NOT KNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant **Husband: Thomas Bostic**
(b) Address **3524 Colorado**
17. (a) **BURIAL** (b) Date thereof **12-18-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **LINCOLN, KCMO**
18. (a) Signature of funeral director **Felipe Greenblatt**
(b) Address **1819 E. 15 KCMO**
19. (a) **12-18-48** (b) **Steraldine Holmes**
(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?
Wound at work _____ (Specify type of place)
Means of injury **E. Frank Ellis**
Signature **E. Frank Ellis** (M. D. or other) **MD**
Address **600 East 22nd St.** Date signed **12/16/48**

OCT 11 1950

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 W. G. Johnson

Licensed Embalmer No. 4383

P. O. Address 1819 E. 15th Ken

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.