

FILED JAN 11 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40430

State File No. \_\_\_\_\_

5450

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5450

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>                                    |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> |  |
| b. CITY OR TOWN <u>Kansas City</u>   | c. LENGTH OF STAY (in this place) <u>4 1/2 yrs</u> | c. CITY OR TOWN <u>Kansas City</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Kansas City Tuberculosis Hospital</u> |  | d. STREET ADDRESS (If rural, give location) <u>802 Tracy</u>   |  |

|   |   |
|---|---|
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>James</u> b. (Middle) <u>Boyle</u> c. (Last) <u>Boyle</u> | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>12-12-1955</u> |
|---|---|

|                    |                               |   |                                       |  |   |  |
|--------------------|-------------------------------|---|---------------------------------------|--|---|--|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>April 1, 1870</u> | 9. AGE (In years, last birthday) <u>85</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 10 HRS. Hours _____ Mins. _____ |
|--------------------|-------------------------------|---|---------------------------------------|--|---|--|

|   |   |  |  |
|---|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>apt. Bldg.</u> | 11. BIRTHPLACE (State or foreign country) <u>Vinita Oklahoma</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
|---|---|--|--|

|                                       |                                       |   |
|---------------------------------------|---------------------------------------|---|
| 13a. FATHER'S NAME <u>Gross Boyle</u> | 13b. MOTHER'S MAIDEN NAME <u>Anna</u> | 14. NAME OF HUSBAND OR WIFE <u>Guby Boyle</u> |
|---------------------------------------|---------------------------------------|---|

|  |  |  |
|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>509-16-3280</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Guby Boyle</u> ADDRESS <u>802 Tracy</u> |
|--|--|--|

|   |   |  |  |
|---|---|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><u>002 1/2</u> |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |  |
|   | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                           |  |  |

|                              |  |   |
|------------------------------|--|---|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------------|--|---|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | 21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____ |
|--|--|---|

|   |  |                                  |
|---|--|----------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? _____ |
|---|--|----------------------------------|

22. I hereby certify that I attended the deceased from 10-31-1955 to 12-12-1955, that I last saw the deceased alive on 12-12-1955, and that death occurred at 802 Tracy, from the causes and on the date stated above.

|   |                                       |                                  |
|---|---------------------------------------|----------------------------------|
| 23a. SIGNATURE <u>Edward P. Altman M.D.</u> (Degree or title) | 23b. ADDRESS <u>L.C.A.B. Hospital</u> | 23c. DATE SIGNED <u>12-12-55</u> |
|---|---------------------------------------|----------------------------------|

|   |                               |   |   |
|---|-------------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Dec. 16 1955</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Leeds</u> | 24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u> |
|---|-------------------------------|---|---|

|  |  |  |
|--|--|--|
| DATE REC'D BY LOCAL REG. <u>12-15-55</u> | REGISTRAR'S SIGNATURE <u>Neva Minshall</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Schmeyer</u> ADDRESS <u>City Mortician</u> |
|--|--|--|

WRITE PLAINLY--USING 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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*J. Vigil Hensick*

Licensed Embalmer No. 3599

Signed.....  
Student Embalmer

P. O. Address Ac Mo

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.