

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35036

State File No. ....

FILED OCT 17 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 280 PRIMARY REG. DIST. NO. 6964 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY <u>Platte</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Platte</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Parkville</u>		c. CITY OR TOWN <u>Parkville</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>6 yrs</u>		STREET ADDRESS (If rural, give location) <u>Rt 5 Breen Acres</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rt 5 Breen Acres</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>J.</u> c. (Last) <u>Boyd</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>9</u> <u>25</u> <u>1956</u>
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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>Jan 10 1876</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during last of working life. If retired, state when retired) <u>Retired Stone Mason</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Hermitage, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Boyd</u>	13b. MOTHER'S MAIDEN NAME <u>Adelina</u>	13c. NAME OF HUSBAND OR WIFE <u>Ethel D. Boyd</u>
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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>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Nellie Farnan</u> ADDRESS <u>Parkville, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia</u>		<u>72 hours</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Hypertension C.V. disease</u>		<u>2 weeks</u> <u>12-15 years</u>
II. OTHER SIGNIFICANT CONDITIONS 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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>443x</u>
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21d. TIME OF INJURY (Month) (Day) (Year): (Hour) (m.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 9/15, 1956, to 9/26, 1956, that I last saw the deceased alive on 9/26, 1956, and that death occurred at 5:05 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>N. A. Farnan M.D.</u>	23b. ADDRESS <u>4030 N Oak St. KC 16 Mo.</u>	23c. DATE SIGNED <u>9/27/56</u>
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Normal</u>	24b. DATE <u>9/29/56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>East Slope Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Platte County Mo.</u>
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DATE REC'D BY LOCAL REG. <u>9-28-56</u>	REGISTRAR'S SIGNATURE <u>Alphie Rollins</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>D. W. Newcome</u> ADDRESS <u>Sons N. K. C.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

57.0



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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..... *Shawn A. Hill*

Licensed Embalmer No. *450*

P. O. Address *K.C. 16,*

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.