Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000620
STATE FILE NUMBER

FILED JAN 23 1959 Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 7

1. PLACE OF DEATH
a. COUNTY: Clay
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: North Kansas City, Missouri — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: North Kansas City Mem. Hosp — Length of stay in 1b: 6hr 15 mi

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Clay
c. CITY OR TOWN: Liberty — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 342 W Kansas — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Minnie Middle: O. Last: Boyer

4. DATE OF DEATH: Month: 1 Day: 11 Year: 59

5. SEX: F **6. COLOR OR RACE**: W **7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: 3-25-1873

9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Ray Co. Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Riley O'Dell
13b. MOTHER'S MAIDEN NAME: Mary Jane Clark
14. NAME OF HUSBAND OR WIFE: Wm. M. Boyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs Edna Shepherd Address: Liberty, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 12 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma Stomach c̄ Metastasis — 6 mo
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 151X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Jan 1957, to Jan 11 59 and last saw ~~him~~ her alive on Jan 11 1959
Death occurred at 8:45 pm p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Glenn W. Hendren MD
22b. ADDRESS: Liberty, Mo.
22c. DATE SIGNED: 1-14-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1-15-59
23c. NAME OF CEMETERY OR CREMATORY: New Hope
23d. LOCATION (City, town, or county) (State): Liberty Mo.

24. FUNERAL DIRECTOR: Church-Archer Co. ADDRESS: Liberty, Mo.
25. DATE RECD. BY LOCAL REG.: 1-14-59
26. REGISTRAR'S SIGNATURE: Marguerite Hudgens

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

JUL 16 1959

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 Harold G. Smith

Licensed Embalmer No. 4575

P. O. Address Liberty, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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