

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024496

FILED VS JUL 29 1959

 Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 127

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>PLATTE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NORTH KANSAS CITY</u>		c. CITY OR TOWN <u>PARKVILLE</u>	
Length of stay in 1b <u>2 HRS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MEMORIAL HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>RT 5</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>D</u> Last <u>Boyd</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-1879</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Sedalia, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Francis Ramey</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHA Sigmon</u>		14. NAME OF HUSBAND OR WIFE <u>William Boyd</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>None</u>		17. INFORMANT Address <u>MRS. Nell FARNAM - Parkville, MO</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u>		<u>2 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary atherosclerosis</u>	<u>unknown</u>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>none.</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 July 21, 1959 to July 21, 1959 and last saw her/him alive on July 21, 1959
Death occurred at 10:38 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>B. Comer Bates, M.D.</u>	22b. ADDRESS <u>9730 South Mall, Antioch Center, Kansas City 16, Mo.</u>	22c. DATE SIGNED <u>7/23/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JULY 23-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EAST SLOPE CEMETERY</u>
23d. LOCATION (City, town, or county) <u>PLATTE COUNTY, Mo.</u>		

24. FUNERAL DIRECTOR <u>D.W. Newcomer's Sons</u>	ADDRESS <u>NORTH KANSAS CITY</u>	25. DATE RECD. BY LOCAL REG. <u>7-23-59</u>	26. REGISTRAR'S SIGNATURE <u>Marguerite Hudgens</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

PLATE

CLAY

LABORER

NORTH KANSAS CITY & HICKS

STATE

MEMORIAL HOSPITAL

1922

JULY 21

BOYD

D

1927

10-1-19

X

FRANCIS KANEY

F. J. BOYD

LABORER

HICKS

BOYD

LABORER

FRANCIS KANEY

LABORER

HICKS

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

John H. Halsbeck

Licensed Embalmer No. 4940

P. O. Address No. Kansas

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.

1922