

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028979

FILED VS AUG 21 1959 149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 3764 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>					
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>unknown</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4123 Independence Ave.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <b>4123 Independence</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or, print) First <b>Joseph</b> Middle <b>W.</b> Last <b>Bosworth Boswell</b>				4. DATE OF DEATH Month <b>August</b> Day <b>2nd</b> Year <b>1959</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <b>unk.</b>	8. DATE OF BIRTH <b>4-27-1887</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (City and state or country) <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY <b>unknown</b>		
13a. FATHER'S NAME <b>unknown</b>			13b. MOTHER'S MAIDEN NAME <b>unknown</b>			14. NAME OF HUSBAND OR WIFE <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes W. W. 2</b>			16. SOCIAL SECURITY NO. <b>487-16-1773</b>		17. INFORMANT Address <b>Sheil Funeral Home Kansas City, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <b>Bronchopneumonia, acute</b> DUE TO (c) <b>Senile degenerative changes</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____						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			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <b>July 59</b> to <b>7-30-59</b> and last saw her/him alive on <b>7/30/59</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>J. Schiller MD</b> (Degree or title)				22b. ADDRESS <b>K. C. Mo.</b>			22c. DATE SIGNED <b>8/4/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-7-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>St. Leavenworth, Kans.</b>					
24. FUNERAL DIRECTOR <b>Sheil Funeral Home Kansas City, Mo.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>8-4-59</b>		26. REGISTRAR'S SIGNATURE <b>Neve Minshall</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Sheil**

STATE- 10-11

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harold B. [Signature]

Licensed Embalmer No. 499

P. O. Address Kansas City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.