

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 6 1960

=60-030525
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4256

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|---|---|---|--|---|--|--|---|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Jackson</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> | | Length of stay in Tb <u>37 years</u> | | c. CITY OR TOWN <u>Kansas City</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>St. Joseph Hospital</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS <u>922 Lopping</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Wilson</u> Last <u>EATON</u> | | | | 4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>60</u> | | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 26 1886</u> | 9. AGE (last birthday) <u>73</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Postal cleaner</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Main Postoffice</u> | | 11. BIRTHPLACE (City and state or country) <u>Cambridge Ill.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | |
| 13a. FATHER'S NAME <u>George Eaton</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Etha Wilson</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Mollie Woods</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 <u>Mrs. Roy Eaton</u> | | | Address <u>922 Lopping</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>Myocardial Failure</u> DUE TO (c) <u>Myocardial Infarction - Coronary Occlusion</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Atherosclerosis - Coronary</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 | | | | | | | | |
| 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 <u> </u> a.m. <u> </u> p.m. <u> </u> | 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 <u>Jan 1 60</u> to <u>present</u> and last saw her/him alive on <u>8/18/60</u> Death occurred at <u>6:58 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>George W. Boyd M.D.</u> | | | | 22b. ADDRESS <u>5111 Independence Ave KC Mo</u> | | 22c. DATE SIGNED <u>8/19/60</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>8/20 60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Morial</u> | | 23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Shelby Funeral Home</u> | | | ADDRESS <u>4606 Grand Ave</u> | | 25. DATE RECD. BY LOCAL REG. <u>8-19-60</u> | | 26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u> | |

DOCUMENT

BY AFFIDAVIT OF Shelby Funeral Home George W. Boyd MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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