

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-046777
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6237

FILED DEC 26 1962

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
1				
2 3218				
3				
4 1				
5 2				
6				
7 0				
8 2				
9 4201				
10				
11				
12 53.2				
13				
BY AFFIDAVIT OF		MEDICAL CERTIFICATION	SHOULD READ	Fowler
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1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
a. COUNTY Jackson		b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Length of stay in 1b 58 Yrs		a. STATE Missouri		b. COUNTY Jackson	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Doctors Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. STREET ADDRESS 6625 E 12th Terr		(If outside, give location)		3. NAME OF DECEASED		4. DATE OF DEATH		Month Day Year	
First MIMA		Middle JANE		Last BOYCE		December 10		1962	
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/4/1875		9. AGE (last birthday) 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Maysville Mo		12. CITIZEN OF WHAT COUNTRY USA		IF UNDER 1 YEAR Months Days Hours Min.	
13a. FATHER'S NAME Emondrue Fowler			13b. MOTHER'S MAIDEN NAME Emiline			14. NAME OF HUSBAND OR WIFE Samuel E Boyce			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None			17. INFORMANT Mrs Alberta Scott 6625 E 12th Terr			
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) Congestive heart Failure								6 wks	
DUE TO (b) Myocardial Posterior wall infarction								6 wks	
DUE TO (c) Coronary artery disease								About 10/4/00	
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 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 <u>10/22-1962</u> to <u>12/9/62</u> and last saw her/him alive on <u>12/9/62</u> Death occurred at <u>12:06 12/10/62 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Wm Fowler DO</i>						22b. ADDRESS 6002 St John		22c. DATE SIGNED 12/10/62	
23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE 12/14/62		23c. NAME OF CEMETERY OR CREMATORY Maple Hill Cemetery		23d. LOCATION (City, town, or county) Kansas City Kansas		(State)	
24. FUNERAL DIRECTOR John P Sheil Kansas City Mo				25. DATE RECD. BY LOCAL REG. 12-10-62		26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>			

Dr. Fowler
6002 S. Stevens

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 Richard E. Carroll

Licensed Embalmer No. 4829

P. O. Address K. E. M.

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.
