

FILED NOV 29 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38338

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 508

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		c. CITY OR TOWN Independence	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Independence San Hosp		d. STREET (If outside, give location) ADDRESS RFD #3 Owens Rd	
3. NAME OF DECEASED (Type or print) Mayme Edith Boman		4. DATE OF DEATH Nov 17 1956	
5. SEX Fm	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-1885
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) Ray Co Mo
13. FATHER'S NAME David Toomay		14. MOTHER'S MAIDEN NAME Rebecca Moade	
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 W.N. Boman Address Independence R 3 Mo
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation			INTERVAL BETWEEN ONSET AND DEATH 1 wk +
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pernicious Anemia			1 yr +
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			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 Month, Day, Year a. m. p. m.			
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 6-12-54 to 11-16-56 and last saw her ^{her} _{him} alive on 11-16-56 Death occurred at 4 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Merrill R. Bay M. D.		22b. ADDRESS Blue Springs, Mo.	22c. DATE SIGNED 11-17-56
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov 19 1956	23c. NAME OF CEMETERY OR CREMATORY Oakland Cem	23d. LOCATION (City, town, or county) (State) RFD Independence Mo
24. FUNERAL DIRECTOR WEBB Funeral Home ADDRESS Blue Springs Mo		25. DATE RECD. BY LOCAL REG. 11-19-56	26. REGISTRAR'S SIGNATURE James Craig

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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 by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *R. B. Webb*.....

Licensed Embalmer No. *2357*.....

P. O. Address *Blue Springs*.....

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