

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009817

STATE FILE NUMBER

FILED MAR 17 1959

Registration District No. 150

Primary Registration District No. 4240

Registrar's No. 63

300  
-573

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Blue Springs</b> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Independence</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1808 Main</b>		Length of stay in lb <b>10 Minutes</b>	d. STREET ADDRESS (If outside, give location) <b>R 3-Williams Rd</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Newton</b> Last <b>Boman</b>	4. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>1959</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16 1882</b>	9. AGE (In years last birthday) <b>76</b>	FUNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>	11. BIRTHPLACE (City and state or country) <b>Norborne Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>Usa</b>
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13a. FATHER'S NAME <b>Pickney Boman</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Smithpeter</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>490-42-7118</b>	17. INFORMANT Address <b>Willie Bell Corne Grain Valley Mo</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arterial sclerotic heart disease</b>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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.)
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20c. TIME OF INJURY Hour <b>5:15</b> a.m. <b>0</b> p.m. <b>0</b>	Month, Day, Year
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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 <b>Independence Mo</b>	COUNTY <b>Mo</b>	STATE <b>Mo</b>
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21. I attended the deceased from <b>3/22/59</b> to <b>2/23/59</b> and last saw him alive on <b>2/23/59</b> Death occurred at <b>5:15</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Merrill B. Bay M.D.</b>	22b. ADDRESS <b>Blue Springs, Mo</b>	22c. DATE SIGNED <b>2/23/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-25-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cem</b>	23d. LOCATION (City, town, or county) <b>Independence Mo R 3</b>
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24. FUNERAL DIRECTOR <b>Webb Funeral Home Blue Springs Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>3-2-59</b>	26. REGISTRAR'S SIGNATURE <b>M.B. Langsford</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *William Free* \_\_\_\_\_

Licensed Embalmer No. *4733*...

P. O. Address *Blue Springs*

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.