

30CT 24 1927

Willelaw

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

26402

1. PLACE OF DEATH

County *Adair*
Township *Salt River*
City *Mexico*

Registration District No. *26*
Primary Registration District No. *3002*

File No. _____
Registered No. *130*

2. FULL NAME *Mrs. Annie Boomer*

(a) Residence, No. _____ St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr. 24 - 1865*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 4 29

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Home maker*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Pennsylvania*

10. NAME OF FATHER *James Cumberland*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Pennsylvania*

12. MAIDEN NAME OF MOTHER *Hanna Kiser*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Ohio*

14. INFORMANT *Mrs. Logan Kiser*
(Address) *Mexico Mo.*

15. *Sept 23 1927* *Ira S. Milligan*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept. 23 1927*

17. HEREBY CERTIFY, That I attended deceased from *Sept. 23*, 19*27*, to *Sept. 23*, 19*27* that I last saw him alive on *Sept. 23*, 19*27*, and that death occurred, on the date stated above, at *6 a m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute dilatation of heart
105 112 95E

CONTRIBUTORY (SECONDARY) *Bronchial Asthma*

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, _____

8 DID AN OPERATION PRECEDE DEATH. DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *R. S. Williams*, M. D.
, 19 (Address) *Mexico Mo.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Mexico Mo Cemetery* DATE OF BURIAL *Sept 24 1927*

20. UNDERTAKER *McPhets Bros* ADDRESS *Mexico Mo.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

