

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36347**

FILED NOV 17 1954

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3990</u>		Registrar's No. <u>403</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Knox</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>			c. LENGTH OF STAY (in this place) <u>3 mo.</u>		c. CITY OR TOWN <u>Edina</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Community Nursing Home</u>				e. STREET ADDRESS (If rural, give location) <u>Mo</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Edward</u>			b. (Middle) <u>Thomas</u>		c. (Last) <u>Boltz</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 9, 1954</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never Married</u>		8. DATE OF BIRTH <u>Feb 8, 1887</u>		9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Know County, Mo</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Allen Boltz</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Hoke</u>		14. NAME OF HUSBAND OR WIFE <u>None</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'S SIGNATURE OR NAME ADDRESS <u>Mrs Martha Edwards, Knox City, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Modulatory Anemia</u> ANTECEDENT CAUSES <u>Uremia</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) <u>Chronic Glomerulonephritis</u>					INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Edina Mo</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from <u>8-2</u> , 19 <u>54</u> to <u>10-9</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Mar 3, 1954</u> , and that death occurred at <u>1:55</u> p.m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>David W. Boone MD</u>				23b. ADDRESS <u>Kirksville Mo</u>		23c. DATE SIGNED <u>10-11-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov 10, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Deer Ridge Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>N. E. La Belle, Mo</u>		
DATE REC'D BY LOCAL REG. <u>11-11-54</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>AS Grimes Edina, Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

X

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 *Mrs J. W. Hudson*.....

Licensed Embalmer No. *297*.....

P. O. Address *Edina*.....

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.