

pt. Health,  
, & Welfare  
S. Public  
alth Service

FILED NOV 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

392225

STATE FILE NUMBER  
1229

Registration District No. 42 Primary Registration District No. 1000

Registrar's No. 1229

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DOA Mo. Methodist Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>2119 No. 3rd St.</b>	
Length of stay in lb <b>10 yrs</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>MARION</b> Last <b>BOLING</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>1957</b>		
---	--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1882</b>	9. AGE (In years last birthday) <b>75</b>	IF FUNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	-------------------------------------	---	---------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Burlington Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Andrew County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
---	---	---	--

13a. FATHER'S NAME <b>Taylor Boling</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Frank</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Katie M. Boling</b>
--	---	--

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>None</b>	17. INFORMANT <b>Mrs. Katie M. Boling</b>	Address <b>St. Joseph, Mo.</b>
--	--	--	-----------------------------------

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>CORONARY OCCLUSION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 MIN.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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)		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.) <b>4201</b>
---	---

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>St. Joseph, Mo.</b>	COUNTY <b>Buchanan</b>	STATE <b>Missouri</b>
---	---	--	--	---------------------------	--------------------------

21. I attended the deceased from <b>NOV. 11, 1957</b> to <b>NOV. 11, 1957</b> and last saw <sup>him</sup> alive on <b>NOV. 11, 1957</b> Death occurred at <b>4:45P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <b>James D. Fisher, M.D.</b>	22b. ADDRESS <b>1302 Farnham St. Joseph, Mo.</b>	22c. DATE SIGNED <b>11-12-57</b>
--	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-13-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Savannah Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Savannah Missouri</b>
---	------------------------------	--	---

24. FUNERAL DIRECTOR <b>Home Funeral Home</b>	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Nov. 14, 1957</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Robert Fulton</b>
--	-----------------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

48

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 *George A. Kirby* .....

Licensed Embalmer No. *4752* .....

P. O. Address *Josephine* .....

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.