LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

20,723a

PLACE OF DEATH

County Bates Registration District No. 186 File No.

Township Charlotte Primary Registration District No. 5078 Registered No. 7

City (No. St. Ward)

FULL NAME Mary E Bolling

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	widowed

IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 24 1855

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
	67	10	12	

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (CITY OR TOWN) Illinois
(STATE OR COUNTRY)

10. NAME OF FATHER Joshua Dickerson

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

12. MAIDEN NAME OF MOTHER Cynthia Collins

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

INFORMANT Chas L Bolling
(Address) Butler Route 5

FILED July 7 1923 C. A. Lusk REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 6 1923

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1923, to July 6, 1923 that I last saw her alive on July 6, 1923, and that death occurred, on the date stated above, at 6 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

122 A
129 Jacked Bowels complicated
Acute Peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J M Smith, M. D

, 19 (Address) Amoret 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Virginia DATE OF BURIAL July 7 1923

20. UNDERTAKER Culvers ADDRESS Butler Mo

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....) ..... St. ..... Ward

2. FULL NAME .....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19
that I last saw h..... alive on....., 19....., at
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

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HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIA
20. UNDERTAKER	ADDRESS