LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

AR 31 1926

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

4415

LACE OF DEATH
County Harison
Township Lincoln
City Hatfield (No. ..... St. ..... Ward)
Registration District No. 346
Primary Registration District No. 5484
File No. 3
Registered No. .....

ULL NAME Anna Marie Bolinger

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

h of residence in city or town where death occurred yrs. mos. 20 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
...ale	White	Single

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

TE OF BIRTH (MONTH, DAY AND YEAR) Feb 2, 1926

E	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
			20	

CUPATION OF DECEASED
a) Trade, profession, or articular kind of work ——
b) General nature of industry, usiness, or establishment in hich employed (or employer) .....
c) Name of employer ——

RTHPLACE (CITY OR TOWN) Hatfield Mo
STATE OR COUNTRY) Harrison co

NAME OF FATHER Harley Bolinger

BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Harrison co Mo

MAIDEN NAME OF MOTHER Lillie Hamlin

BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Gentry Co Mo

FORMANT Harley Bolinger
Address) Hatfield Mo

LED 2/23 1926. Chas Adair
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2 — 22 1926

17. I HEREBY CERTIFY, That I attended deceased from 2 — 2, 1926, to 2 — 22, 1926, that I last saw her alive on 2 — 2, 1926, and that death occurred, on the date stated above, at 5 — 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Enteritis

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

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) A W Reynolds, M. D
, 19 (Address) Hatfield 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	DATE OF BURIAL
Kirk Cemetery	2 — 24 1926
20. UNDERTAKER	ADDRESS
No Undertaker	

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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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. .....Wa

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) 1

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

CONTRIBUTORY.....
(SECONDARY)

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