

**BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH

County Bollinger
Township Filmore
City (No.)

Registration District No. 69

Primary Registration District No. 5-105-

File No. 8746-a

Registered 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.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OF

Royse J. Bollinger

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

Dec 8 1853

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, ... hrs.
or min.

77

3

9

8. OCCUPATION OF DECEASED

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

Farming

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

—

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Castor P.O.

(STATE OR COUNTRY)

Bollinger Co., Mo.

10. NAME OF FATHER

David Bollinger

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Bollinger Co., Mo.

12. MAIDEN NAME OF MOTHER

Elizabeth Whitener

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Bollinger Co., Mo.

14. INFORMANT

(Address)

Forest Bollinger

Green Allen Mo.

15. FILED

19.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Mar 17 1931

17.

I HEREBY CERTIFY, That I attended deceased from

1930, to

Mar 17, 1931

that I last saw him alive on Mar 12, 1931, and that death occurred, on the date stated above, at 4 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bright's Disease

132A

137

(duration) 10 yrs. 10 mos. 10 ds.

CONTRIBUTORY (SECONDARY)

Prostatic Hypertrophy

(duration) 10 yrs. 10 mos. 10 ds.

18. WHERE WAS DISEASE CONTRIBUTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF 1

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

Adam F. Wagner, M.D.

3-18, 1931 (Address)

Gravelton, 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

DATE OF BURIAL

Kinder Chapel Cem.

3-19 1931

20. UNDERTAKER

ADDRESS

Andrew Baker

Lutesville

JUN 24 1931

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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Dallinger
Township Filmore
City _____ (No. _____)

Registration District No. 69
Primary Registration District No. 5705-

File No. _____
Registered No. _____

2. FULL NAME

Daniel Emory Bollinger

(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

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR
DIVORCED (write the word)

m

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)

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.

FILE

5-20-31

D. J. Vergetich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Mar 17 19 31

17.

I HEREBY CERTIFY, That I attended deceased from _____

to _____, to _____, 19____
that I last saw h. _____, since on _____, 19____, and that
death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY
(SECONDARY)

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) _____, M. D.

, 19 (Address)

*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

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im-

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-8746-A