

APR 21 1937

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

Do not use this space.

1. PLACE OF DEATH

County

Township

City

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

St.

Ward)

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

St.

Ward.

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

Mrs. Bertha Bollinger

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

Dec. 7th 1861

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Physician

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

about 2 yrs ago

51

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Marshfield Missouri

13. NAME

John Bollinger

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Pennsylvania

15. MAIDEN NAME

Huldah Foster

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Tenn.

17. INFORMANT (ADDRESS)

Garnett Buess,

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Seymour, Mo.

DATE

Mar. 19 1937

19. UNDERTAKER (ADDRESS)

H. H. H. - H. H. H.

20. FILED

Mar 19 1937

Chas A. George, Mo. Registrar

MEDICAL CERTIFICATE OF DEATH

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

Mar. 19th 1937

22. I HEREBY CERTIFY, That I attended deceased from

2/19 1937, to 3/19 1937

I last saw him alive on 3/8 1937

Death is said to have occurred on the date stated above, at 6:40 A.M.

The principal cause of death and related causes of importance were as follows:

Post-operative cardiac failure Date of onset 3/13/37

Other contributory causes of importance:

Hemiplegia R. 3/15/37

Name of physician attending at date of death

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.

822



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.

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

Do not use this space.

1. PLACE OF DEATH

County Greene

Registration District No. 318

File No. 11934

Township Springfield

Primary Registration District No. 2001

Registered No. _____

City Springfield (No. _____)

St. _____ Ward _____

2. FULL NAME

Dr. William H. 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

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

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than day, _____ hr. or _____ min.

75

3

12

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19__

19. UNDERTAKER (ADDRESS)

20. FILED 6-10 1937 Chas A George Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 19 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, 19__, to _____, 19__

I last saw him _____ alive on _____, 19__. Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Post operative cardiac failure

Cerebral hemorrhage

Other contributory causes of importance:

Hypertrophy prostate

Superficial Prostatectomy

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury 3-19-1937

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) W. F. Williams M. D.

(Address) Springfield mo

S-11931