

FILED NOV 6 1941

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. 106

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County CARROLL  
(b) City or town CARROLLTON MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
205 NORTH HALE  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME CLARA MABLE BOLINGER

3. (b) If veteran, name war - 3. (c) Social Security No. -

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ALFRED BOLINGER 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased JUNE 11 1899  
(Month) (Day) (Year)

8. AGE: Years 42 Months 4 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace GENTRY COUNTY MO  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

MOTHER FATHER { 11. Industry or business \_\_\_\_\_  
12. Name DAYE HOLMES  
13. Birthplace GENTRY COUNTY MO  
(City, town, or county) (State or foreign country)  
14. Maiden name LEONIA STANLEY  
15. Birthplace GENTRY COUNTY MO  
(City, town, or county) (State or foreign country)

16. (a) Informant ALFRED BOLINGER  
(b) Address CARROLLTON MO

17. (a) BURIAL (b) Date thereof OCT 23 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DAIR HILL

18. (a) Signature of funeral director E. J. JAMES  
(b) Address CONCORDIA MO

19. (a) 10-22-41 (b) John Hooker  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CARROLL  
(c) City or town CARROLLTON MO  
(If outside city or town limits, write "RURAL")  
(d) Street No. 205 NORTH HALE  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 21  
year 1941 hour 12 minute 59 AM

21. I hereby certify that I attended the deceased from Aug 12  
1941 to OCT 21 1941  
that I last saw her alive on OCT 20 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Senecaria  
Due to Peritonium  
Duration 6 mo.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: 73a  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature P. Hamilton M. D. or other \_\_\_\_\_  
Address Lawrence 9 Mo Date signed Oct 23 1941

REGISTRATION  
DISTRICT HEALTH OFFICER NO. 8  
DATE FOR NUMBER  
11-5-41

**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 me  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed E. S. James  
Licensed Embalmer No. 2058  
P. O. Address Conordia Mo.

**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 this body is not embalmed, fact should be so stated above.