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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN - 5 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 90

Registration District No. 1318 Primary Registration District No. 1003 Registrar's No. 117

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital Max C. Starkloff Memorial (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 days (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 96

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis County (If outside city or town limits, write "RURAL") NR

(d) Street No. 6212 Clemens Ave. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John F. Bolton

3. (b) If veteran, name war

3. (c) Social Security No. 491-18-0380

4. Sex Male

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Elizabeth Bolton

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased June (Month) 2nd. (Day) 1865 (Year)

8. AGE: Years 78 Months 7 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) Cal. (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Adams Stamp and Sta. Co.

FATHER
12. Name ? Bolton
13. Birthplace (City, town, or county) Cal. (State or foreign country)

MOTHER
14. Maiden name ? Kennedy
15. Birthplace (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Elizabeth Bolton
(b) Address 6212 Clemens Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-44 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Provost Und. Co.
(b) Address 3710 N. Grand Bl.

19. (a) JAN 5 1944 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 4 year 1944 hour 7:55 minute A M.

21. I hereby certify that I attended the deceased from December 16, 1943, to January 4, 1944 that I last saw him alive on January 4, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Peripheral Circ. Collapse

Due to Senile Psychosis Arteriosclerotic Ht. Disease

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (Dr. or other)

Address 1515 Lafayette Avenue Date signed 1/4/44

(Licensed Embalmer's Statement on Reverse Side)

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Robert L. Binkman

Licensed Embalmer No. 3553

P. O. Address 3710 N Grand

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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