

FILED MAY 4 1945
Registration District No. **223**

Primary Registration District No. **5795**

Registrar's No. **3**

1. PLACE OF DEATH:
(a) County Moniteau
(b) City or town California
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution !
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 64 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Moniteau
(c) City or town Rural Pilot Springs
(If outside city or town limits, write "RURAL")
(d) Street No. 6 mile south West California Mo.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ANNA BELL BOLINGER
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 4
year 1945 hour 8 minute A.M.
21. I hereby certify that I attended the deceased from Feb 2
1945 to April 4 1945
that I last saw her alive on April 1 1945
and that death occurred on the date and hour stated above.

4. Sex F **5. Color or race** W **6. (a) Single, widowed, married** 1 divorced Married
6. (b) Name of husband or wife. John Henry Bolinger **6. (c) Age of husband or wife if** alive 65 years
7. Birth date of deceased July 7 1882
(Month) (Day) (Year)

Immediate cause of death:
Chronic Nephritis Duration 2 year
Chronic Myocarditis 2 year

8. AGE: Years 62 Months 8 Days 28 If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

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

10. Usual occupation Housewife

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name Jane B. Allen
13. Birthplace Moniteau Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Barbara Ann Scott
15. Birthplace Moniteau Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Melan Miller
(b) Address California Mo.

17. (a) Burial, cremation, or removal Flag Spring Cem. **(b) Date thereof** 4-5-1945
(Month) (Day) (Year)

(c) Place: burial or cremation Flag Spring, Moniteau

18. (a) Signature of funeral director High E. Williams
(b) Address California Mo.

19. (a) 4-5-1945 **(b) Mrs. H. J. Sullivan**
(Date received local registrar) (Registrar's signature)

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 Raymond Latham (M. D. or other) _____
Address California, Mo. **Date signed** 4-5-45

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 5-2-45

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

Hugh L. E. Williams

Licensed Embalmer No. 3537

P. O. Address _____

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.

2B
13
38930

State File No. May
Registrar's No. 30

Registration District No. 223

Primary Registration District No. (5495)

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

1. PLACE OF DEATH:

(a) County Monteau

(b) City or town New California MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Rural Pilot Grove Twp
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monteau

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. Rural near California
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Anna Bell Bolinger

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased July (Month) 1 (Day) 1921 (Year)

8. AGE: Years 62 Months 8 Days no If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

{ 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

{ 14. Maiden name _____

{ 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mrs H. J. Sullivan (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: 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 _____ (M. D. or other) _____

Address _____ Date signed _____

