No. 2
8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21502

Registration District No. 336 Primary Registration District No. 6157 Registrar's No. 21502

1. PLACE OF DEATH:
(a) County Rural, Shannon
(b) City or town Winona, Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: No (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No (Specify whether)
In this community 37 Years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Shannon
(c) City or town Winona, Mo (If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Joseph E. Bolin
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Susie Bolin
6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased March (Month) 29th (Day) 1882 (Year)

8. AGE: Years 63 | Months | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Farming
11. Industry or business

MOTHER
12. Name H.W. Bolin
13. Birthplace ____ (City, town, or county) Tenn. (State or foreign country)

FATHER
14. Maiden name Laura Clary
15. Birthplace ____ (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Fred R. Bolin
(b) Address Winona, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mungel Chapel Cem,
18. (a) Signature of funeral director John T. Duncan
(b) Address Mountain View, Mo
19. (a) 3-25-45 (Date received local registrar) (b) Frank Hyde M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24th year 1945 hour 6 minute 15 A.M.
21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	
Due to	
Due to	
Other conditions Coronal Coma (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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Frank Hyde (M. D. or other)
Address Peculiar, Mo Date signed 3-25-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 645-291
Date Filed Dec 15-45

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 John F. Duncan

Licensed Embalmer No. 2516

P. O. Address New Vienna 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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 236 Primary Registration District No. 6137 Registrar's No.

1. PLACE OF DEATH:

(a) County Shannon

(b) City or town Rural W prong Twp
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Joseph E. Bolin

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

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 Mar 24 1882
(Month) (Day) (Year)

8. AGE: Years 63 Months 10 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (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)

MOTHER

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 14 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Broncho Pneumonia	
Due to	
Due to 107	
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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Frank Hyde (M. D. or other)

Address Purdy Mo. Date signed

SUPPLEMENTARY

21502