. No. 2
—8-43
5-17-39
I X37823

3

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 16 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34836

Registration District No. 339 Primary Registration District No. 6150 Registrar's No. 14

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Rural [illegible]
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: [illegible]
(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 Stoddard 103

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME William P. Bollinger,

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M D

5. Color or race W

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

6. (b) Name of husband or wife Almoria,

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

7. Birth date of deceased March (Month) 3 (Day) 1871 (Year)

8. AGE: Years 74 Months 6 Days 11 If less than one day ..... hr. ..... min.

9. Birthplace Tillman (City, town, or county) Missouri, (State or foreign country) 0

10. Usual occupation .....

11. Industry or business Farming

FATHER
12. Name Hit Bollinger
13. Birthplace Tillman (City, town, or county) Missouri, (State or foreign country) 0

MOTHER
14. Maiden name Kathrine Perry
15. Birthplace Stoddard County Mo (City, town, or county) (State or foreign country) 0

16. (a) Informant Almoria Bollinger
(b) Address Puxico Mo,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 (Month) 16 (Day) 1945 (Year)
(c) Place: burial or cremation Plesant Hill,

18. (a) Signature of funeral director Watkins Service
(b) Address Puxico Mo,

19. (a) 9-17-1945 (Date received local registrar) (b) J W Steinmeier (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14
year 1945 hour 10 minute A M.

21. I hereby certify that I attended the deceased from May 22, 1945, to Sept 14, 1945;
that I last saw him alive on Sept 13, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congestive heart failure	
Due to Hypertension	
Due to Chronic Glomerulo-nephritis	?
Other conditions Bronchial Asthma (Include pregnancy within 3 months of death)	2 yrs

Major findings:
Of operations .....
Of autopsy .....

131b

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 V H Skelling (M. D. or other) D.
Address Puxico Mo. Date signed 9/17/45

1132

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 10 45 - 312
Date Filed 10-16-45

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 Lyman L Steel

Licensed Embalmer No. 2476

P. O. Address Dexter 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.