S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

FILED SEP 30 1946

State File No. 29707

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 313

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: Callaway Co. Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether

In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Callaway 14

(c) City or town Fulton 1
(If outside city or town limits, write "RURAL")

(d) Street No. 310 east 1st 2
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME James Albert Bolton

3. (b) If veteran, name war No

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

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

6. (c) Age of husband or wife if alive 15 years

7. Birth date of deceased April 6 1867
(Month) (Day) (Year)

8. AGE: Years 79 Months 5 Days 15 If less than one day hr. min.

9. Birthplace Callaway Co. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Attendant State Hosp.

11. Industry or business

FATHER
12. Name Albert Bolton
13. Birthplace Memphis Tenn. 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Callie Potts
15. Birthplace McCredie Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Della Bolton
(b) Address Fulton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-46
(Month) (Day) (Year)
(c) Place: burial or cremation Mt. Carmel Fulton, Mo.

18. (a) Signature of funeral director Wallace Funeral Home
(b) Address Fulton, Mo.

19. (a) 9-24-1946 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 21
year 1946 hour 7 minute 35 P.M.

21. I hereby certify that I attended the deceased from Jan, 1946, to 9-21, 1946
that I last saw him alive on 9/21, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, Bronchio — Duration 3 days

Due to Cerebral Arteriosclerosis with hemoplegia

Due to Gen. Arteriosclerosis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 107

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 0

23. Signature George F. Wood (M. D. or other) MD

Address Fulton, Mo. Date signed 9/23/46.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9
District File Number 9-46-154
Date Filed 9-30-46

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 Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address Fulton 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.