

FILED JUL 17 1947

Registration District No. **47**

Primary Registration District No. **3008**

Registrar's No. **240**

1. PLACE OF DEATH:

(a) County **Callaway**
(b) City or town **Fulton, Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital No 1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 yrs, 2 mo 9 26 days**
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME **Mary Bolander**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **Unknown**

4. Sex **female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **divorced**

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **Unknown** years

7. Birth date of deceased **march 24 1877**
(Month) (Day) (Year)

8. AGE: Years **70** Months **3** Days **7** If less than one day hr. min.

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

10. Usual occupation **House work**

11. Industry or business _____

12. Name **Frank Ford**

13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

14. Maiden name **M. alt. Baldwin**

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

16. (a) Informant **State Hospital Records**

(b) Address **Fulton, Mo**

17. (a) **Burial** (b) Date thereof **7-9-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **State Hosp. Cemetery**

18. (a) Signature of funeral director **J. P. Hall**

(b) Address **State Hosp. Fulton Mo**

19. (a) **7-9-47** (b) **Joel Morrison**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**
(c) City or town **Independence**
(If outside city or town limits, write "RURAL")
(d) Street No. **County Home**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **1st**
year **1947** hour **7** minute **0** P.M.

21. I hereby certify that I attended the deceased from **5 April**
1945 to **1 July 1947**

that I last saw her alive on **July 1 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Generalized T.B.C.** Duration
Pulmonary Tuberculosis **18 mo**

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 **G.S. Warick** (M. D. or other) _____

Address **State Hospital No 1** Date signed **1 July 47**

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

MOTHER FATHER

14
2
✓

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 7-16-42

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.....

Licensed Embalmer No.....

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.