

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

33660

State File No. _____
Registrar's No. 74

FILED NOV 5 1947

Registration District No. 22

Primary Registration District No. 5715

1. PLACE OF DEATH:

(a) County Bollinger Co.
(b) City or town Rural Whitewater.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Miller's Hospital, Miller's Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community All Life
years, months or days

3. (a) PRINT FULL NAME Eva Elizabeth Bollinger

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 Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 24 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 9 3 hr. 6 min.

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

10. Usual occupation House Wife

11. Industry or business _____

MOTHER FATHER { 12. Name Albert Jack Smith
13. Birthplace Bollinger Co. (City, town, or county) (State or foreign country)
14. Maiden name Emma Doggett
15. Birthplace Bollinger Co. (City, town, or county) (State or foreign country)

16. (a) Informant O.E. Bollinger

(b) Address Millersville Mo.

17. (a) Burial (b) Date thereof Oct. 30 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Patton Mo.

18. (a) Signature of funeral director J.S.S.

(b) Address Jackson Mo.

19. (a) Oct. 31 1947 (b) Willie Van Amburgh
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bollinger
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. 3 Miles West Of Sedgewick Ville Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27th year 1947 hour 4 minute 15 M.
21. I hereby certify that I attended the deceased from Oct 27th 1947, to Oct 27th 1947.
that I last saw him alive on Oct 27th and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
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 Calvin Crites (M. D. or other) 10/30/47
Address Sedgewickville Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

NOV 20 1947

RECEIVED

Health Officer No. 4

File Number 1147-139

Filed 11-4-47

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 W. H. Foster

Licensed Embalmer No. 3568

P. O. Address. Cape Girardeau

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.