

FILED NOV 6 1947

Registration District No. **5183**

Registrar's No. **69**

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

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Rural Byrd 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

3. (a) PRINT FULL NAME James Covington Bollinger

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 Widowed

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

7. Birth date of deceased July 18 1862
(Month) (Day) (Year)

8. AGE: Years 85 Months 2 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Abraham Bollinger

13. Birthplace North Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Statler

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Arthur Phillips

(b) Address Jackson mo.

17. (a) Burial (b) Date thereof 9/20/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Russel Heights Cem

18. (a) Signature of funeral director W. G. Wilson

(b) Address Jackson, Mo.

19. (a) 9-20-47 (b) D. G. Sullivan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Gir.

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

(d) Street No. 4 Miles North west of Jack-
(If rural, give location) SONOMO.

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 18
year 1947 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from Saw wound
9-17 1947 to last no treatment 19
that I last saw him alive on Sept 18th 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Central Hemorrhage Duration 3 days

Due to _____

Due to _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. D. Blaylock M.D. (M. D. or other)

Address Oak Ridge, Mo. Date signed 9-20-47

RECEIVED

District Health Officer No. 4
District File Number 1147-1398
Date Filed 11-5-42

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 Thos K. Allen

Licensed Embalmer No. 4055-

P. O. Address Jackson

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.