

S. No. 2
M-2-43
r. 5-17-39
P-1 X35097

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37286

FILED DEC 11 1947

State File No. _____

Registration District No. 17

Primary Registration District No. 300F

Registrar's No. 419

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: _____

(If not in hospital or institution, write street number or location) 1

(d) Length of stay: In hospital or institution Since 11-26-47
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Montgomery ⁷⁰

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

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

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

If yes, name country _____

3. (a) PRINT FULL NAME Mary J. Kolling

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 30
year 1947 hour 11 minute 20 P.M.

21. I hereby certify that I attended the deceased from 11-26, 1947, to 11-30, 1947
that I last saw her alive on 11-30, 1947
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife Chas. J. Kolling

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

7. Birth date of deceased: Sept 28 1876
(Month) (Day) (Year)

Immediate cause of death Bronchopneumonia Duration 4 days

8. AGE: Years 71 Months 2 Days 2 If less than one day _____ hr. _____ min.

Due to _____

Due to _____

Other conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)
and mentally deranged

MOTHER FATHER

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

10. Usual occupation housewife

11. Industry or business _____

12. Name James Jeans

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

14. Maiden name Elizabeth Summers

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

Major findings:
Of operations none done

Of autopsy none granted

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Hosp. records

(b) Address _____

17. (a) Removal (b) Date thereof 12-1-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Piper Branch

18. (a) Signature of funeral director B. A. Harding

(b) Address of owning me

19. (a) 12-1-1947 (b) Joan M. ...
(Date received local registrar) (Registrar's signature) (Date)

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 _____

Signature J. C. Caldwell Jr. (M. D. or other) 0
Address Hwy #1 - Fulton Date signed 11-30-47

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

Date Filed (2-10-48)

District File No.

District Health Officer No. 9,

RECEIVED

APR 27 1948

SEP 6 1953

AUG 10 1953

SEP 1 1948

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 *Paul A. Harding*

Licensed Embalmer No. *4115*

P. O. Address *Canaan, 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.