

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUN 24 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

18660

Registration District No. 32

Primary Registration District No. 5114

State File No. _____

Registrar's No. 43

1. PLACE OF DEATH:

(a) County Bollinger
(b) City or town RURAL - WAYNE 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 years, months or days)
In this community 1 DAY

3: (a) PRINT FULL NAME BURK C BOLLINGER

3: (b) If veteran, name war WW II 3: (c) Social Security No. 490-14-108

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife JEWELL SMITH BOLLINGER 6. (c) Age of husband or wife if alive 26 years
7. Birth date of deceased FEB 3 1916
(Month) (Day) (Year)

8. AGE: Years 32 Months 4 Days 5 If less than one day hr. min.

9. Birthplace POPLAR BLUFF MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation R.R. BRAKEMAN

11. Industry or business _____

12. Name EVERETT BOLLINGER

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

14. Maiden name LULU PATTERSON

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

16. (a) Informant Mrs BC Bollinger

(b) Address Illmo, Mo.

17. (a) Burial (b) Date thereof JUNE 10 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chaffin Mo

18. (a) Signature of funeral director Bisplinghoff

(b) Address Illmo, Mo.

19. (a) JUNE 10 1948 (b) Willie Vandenberg
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County SCOTT 100
(c) City or town ILLMO 3
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? NO (Yes or No) 1
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 8
year 1948 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Asphyxiation

Due to Accidental Drowning

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)

(2) Means of injury 3

23. Signature John F. Morris M. D. or other _____

Address Butte Falls Mo Date signed 6/10/48

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

RECEIVED

District Health Officer No. 4

File Number 648-80

Date Filed 6-23-48

JUN 28 1948

JUN 28 1948

JUN 28 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 Oliver Amick

Licensed Embalmer No. 4470

P. O. Address Illmo, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
431
Registrar's No. _____

Registration District No. 32

Primary Registration District No. 5114

1. PLACE OF DEATH:

(a) County Bollinger
(b) City or town Marion
(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

Burl C 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 m

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Jul 3
(Month) (Day) (Year)

8. AGE: Years 32 Months 4 Days 10
If less than one day
hr. min.

9. Birthplace _____
(City, town, or county)

(State or foreign country) Mo

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

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 sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident
(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 John J. Moore (M. D. or other) 20
Address Intergal 9110 Date signed _____

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

SUPPLEMENTARY

5-18660