

FILED FEB 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2378
Registrar's No. 28

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075

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

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Scott	
b. CITY (If outside corporate limits, write RURAL and give township) OR Farmington TOWN RURAL St. Francois		c. CITY (If outside corporate limits, write RURAL and give township) OR Oran TOWN RURAL	
c. LENGTH OF STAY (In this place) 1yr. 3mos.		d. STREET ADDRESS (If rural, give location) Unknown	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri State Hospital No. 4			

3. NAME OF DECEASED (Type or Print)	a. (First) CORNELIUS	b. (Middle) WILLIAM	c. (Last) BOLLINGER	4. DATE OF DEATH (Month) (Day) (Year) January 22, 1949
-------------------------------------	----------------------	---------------------	---------------------	---

5. SEX Male <input checked="" type="radio"/>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH December 9, 1902	9. AGE (In years last birthday) 46	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 13	Hours	Min.
---	---------------------------	---	--------------------------------------	------------------------------------	-----------------------------	-----------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Oran, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	---	--

13a. FATHER'S NAME Michael Bollinger	13b. MOTHER'S MAIDEN NAME Emelia Heisserer	14. NAME OF HUSBAND OR WIFE None
---	---	-------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Records State Hospital No. 4, Farmington, Mo.	ADDRESS.
---	---------------------------------	--	----------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 day.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Vascular Syphilis DUE TO (c)		Apt. 15 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with General Paresis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

21a. ACCIDENT (Specify) SUICIDE HOMICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 3, 1947 to Jan. 22, 1949, that I last saw the deceased alive on Jan. 22, 1949, and that death occurred at 6:40 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John L. Brennan M.D.	23b. ADDRESS State Hospital No. 4, Farmington, Mo.	23c. DATE SIGNED 1/25/49
--	---	-----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 24, 1949	24c. NAME OF CEMETERY OR CREMATORY Old Guardian Angel Cem.	24d. LOCATION (City, town, or county) (State) Oran, Missouri
---	----------------------------	---	---

DATE REC'D BY LOCAL REG. 1-25-1949	REGISTRAR'S SIGNATURE Ether Rudolph	25. FUNERAL DIRECTOR'S SIGNATURE Earl J. Smith	ADDRESS Oran, Missouri
---------------------------------------	--	---	---------------------------

Officer No. 4
Number 249-195
Date Filed 2-7-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Earl J. Smith

Signed _____
Student Embalmer

Licensed Embalmer No. 8676

P. O. Address Ocean, 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.