

FILED APR 21 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12853

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 1634	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City, Mo		c. LENGTH OF STAY (in this place) 3 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City			
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital #1				d. STREET ADDRESS Coates House 10th. & Broadway 312-8			
3. NAME OF DECEASED (Type or Print) a. (First) Clarence			b. (Middle) Eugene		c. (Last) Bolin		4. DATE OF DEATH (Month) (Day) (Year) 4-6-50
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced ?		8. DATE OF BIRTH 6-11-03	9. AGE (in years last birthday) 46	10. MONTHS	11. HOURS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper		10b. KIND OF BUSINESS OR INDUSTRY Advertising		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Alfred Bolin		13b. MOTHER'S MAIDEN NAME Emily Matson		14. NAME OF HUSBAND OR WIFE Dorothy Bolin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 498-01-1997		17. INFORMANT'S SIGNATURE OR NAME General Hospital Records		ADDRESS K.C. Mo.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Portal Cirrhosis of the liver Fatty metamorphosis (b) Massive Broncho-pneumonia (c) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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)	
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 3-23-50, 19, to 4-6-50, 19, that I last saw the deceased alive on 4-6-50, 19, and that death occurred at 4PM m., from the causes and on the date stated above.							
23a. SIGNATURE Wm. W. Hart (Degree or title)				23b. ADDRESS Med. Director General Hosp #1		23c. DATE SIGNED 4-6-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 4-7-50	24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Minneapolis Minn.		
DATE REC'D BY LOCAL REG. 4-7-50		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE Mrs. C. L. Forster		ADDRESS K.C. Mo.	

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

1951

MAR 8 1951

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.

Student \_\_\_\_\_  
Student Embalmer

Signed \_\_\_\_\_

*Joe B. Yoder*

Licensed Embalmer No. *4173*

P. O. Address \_\_\_\_\_

*K. C. 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.