

FILED JAN 10 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42777**
Registrar's No. **11359**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (in this place) 2 DAYS		d. STREET ADDRESS (If rural, give location) 4016 Page - Blvd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CHILDREN'S HOSPITAL			

3. NAME OF DECEASED a. (First) LEONARD b. (Middle) ROLLINS c. (Last) BOLAR			4. DATE OF DEATH (Month) (Day) (Year) 12 19 51		
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Y	
8. DATE OF BIRTH 7-27-42		9. AGE (In years last birthday) 9		10. IF UNDER 1 YEAR: Months 5 Days 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis - Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.A					

13a. FATHER'S NAME LEONARD BOLAR		13b. MOTHER'S MAIDEN NAME JUSTINE ROLLINS		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME R.B. HARRISON ADDRESS 500 S. Kemp High	

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) osteogenic sarcoma ANTECEDENT CAUSES with Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) multiple pulmonary DUE TO (c) metastases			INTERVAL BETWEEN ONSET AND DEATH
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 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 196X	

22. I hereby certify that I attended the deceased from **12-17, 1951**, to **12-19, 1951**, that I last saw the deceased alive on **12-19, 1951**, and that death occurred at **11:45 AM**, from the causes and on the date stated above.

23a. SIGNATURE Am L Thurston M.D. (Degree or title)		23b. ADDRESS		23c. DATE SIGNED	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-24-51		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis County Mo	
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DATE REC'D BY LOCAL REG. DEC 22 1951		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE W.P. Richardson ADDRESS 2625 Glasgow	
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....

working under my personal supervision.

Student Embalmer No.....

Signed *A.D. Richardson*

Signed.....
Student Embalmer

Licensed Embalmer No. *2928*

P. O. Address *2625 Glasgow*

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.