

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9714

FILED MAR 29 1952

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2262**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Texas</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR <b>St Louis Mo</b> TOWN		c. LENGTH OF STAY (in this place) <b>5 days</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES Hospital</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR <b>Houston</b> TOWN <b>1070</b>	
3. NAME OF DECEASED a. (First) <b>EDNA</b> b. (Middle) <b>ELIZABETH</b> c. (Last) <b>BOLGARD</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>3 - 10 - 52</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov 8 1877</b>
9. AGE (in years last birthday) <b>74</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	11. BIRTHPLACE (State or foreign country) <b>Crocker, Missouri</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>John Shelton</b>		13b. MOTHER'S MAIDEN NAME <b>Unavailable</b>	14. NAME OF HUSBAND OR WIFE <b>Theodore Bolgard</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No Nil</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Theodore Bolgard-Houston, Missouri</b>
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) <b>CEREBRAL VASCULAR ACCIDENT</b>  ANTECEDENT CAUSES DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE &amp; ARTERIOSCLEROTIC HEART DISEASE</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"/>		INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTHS</b>	
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? <b>H200</b>	
22. I hereby certify that I attended the deceased from <b>3 - 5, 1952</b> to <b>3 - 10, 1952</b> , that I last saw the deceased alive on <b>3 - 10, 1952</b> and that death occurred at <b>2 A. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>C. D. Vanellin, M.D.</b>		23b. ADDRESS <b>Barnes Hospital</b>	
23c. DATE SIGNED <b>3/10/52</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
24b. DATE <b>3-10-52</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Oak Dale Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>Houston, Missouri.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe-4700 Washington Blvd</b>	
DATE REC'D BY LOCAL REG <b>MAR 10 1952</b>		REGISTRAR'S SIGNATURE <b>Carl Smith, MD</b>	

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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*J. Wm. Berkeley*

Licensed Embalmer No.

*3653*

P. O. Address

*St. Louis, 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.