

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41545

State File No.

FILED DEC. 19 1955

BIRTH NO. _____ REG. DIST. NO. 273 PRIMARY REG. DIST. NO. 3051 Registrar's No. 122

1. PLACE OF DEATH a. CITY <u>Perry</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Perryville</u> c. LENGTH OF STAY (in this place) <u>6 Mo.</u> d. FULL NAME OF HOSPITAL OR INSTITUTION (if not in hospital or institution, give street address or location) <u>Perryville Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> COUNTY <u>Cape Girardeau</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Oak Ridge</u> d. STREET ADDRESS (If rural, give location) <u>None</u>	
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

3. NAME OF DECEASED a. (First) <u>AUGUSTINE</u> b. (Middle) <u>KATHERINE</u> c. (Last) <u>BOLLINGER</u> (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 12 1955</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Feb. 23, 1886</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Henry Heider</u>		13b. MOTHER'S MAIDEN NAME <u>Sophie Boetker</u>		14. NAME OF HUSBAND OR WIFE <u>Chas. Bollinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Marie Wasem St. Louis, Mo.</u>	

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) <u>Generalized Cerebral Arteriosclerosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>334X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yr.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Multiple decubitus ulcers</u>		<u>6 mo.</u>				

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m.		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 10-1, 1955, to 12-12, 1955, that I last saw the deceased alive on 11-29, 1955, and that death occurred at 9:00P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. F. Fairchild, M.D.</u>		23b. ADDRESS <u>Perryville, Mo.</u>		23c. DATE SIGNED <u>12-14-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Dec. 16, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights</u>	
24d. LOCATION (City, town, or county) (State) <u>Jackson Mo</u>		DATE REC'D BY LOCAL REG. <u>12-14-55</u>		REGISTRAR'S SIGNATURE <u>Jos. J. Zollner</u>	
FUNERAL DIRECTOR'S SIGNATURE <u>M. Combs</u>		ADDRESS <u>Funeral Home Jackson, Mo.</u>		(Licensed Embalmer's Statement on Reverse Side)	

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 B. A. Meyer

Licensed Embalmer No. 305-1

P. O. Address Jackson

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.