

FILED MAY 13 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11921

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 3000 Registrar's No. 175

Health,  
Welfare  
Public  
Service

0013  
300  
1-56

securing the medical certification in the specific manner required by 179.140, no verbal report.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>Kirksville,</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Browning</u> <u>KIRKSVILLE,</u> <u>1050</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Grim Smith Hospital</u> Length of stay in 1b <u>13 days</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Payne Bolling</u> First Middle Last			4. DATE OF DEATH <u>May 2 57</u> Month Day Year
5. SEX <u>Male</u> 0	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1877</u>
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>23</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Browning, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Beverly D. Bolling</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah O. Fleming</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. <u>489403319</u>		17. INFORMANT <u>Ada Bolling, wife</u> Address <u>Browning, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Auricular Flutter</u>			<u>1 mo.</u>
DUE TO (c) <u>Chronic Myocarditis</u>			<u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4222</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY: Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>4-18-57</u> to <u>5-2-57</u> and last saw <sup>him</sup> <u>alive</u> on <u>5-2-57</u> Death occurred at <u>9:50 A. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>Kirksville, Mo.</u>	22c. DATE SIGNED <u>5-2-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-5-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Knifong Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Browning Rural Mo.</u>
24. FUNERAL DIRECTOR <u>Wade Funeral Home</u> ADDRESS <u>Browning, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>5-7-1957</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Rathff</u>

(Licensed Embalmer's Statement on Reverse Side)

JUL 5 1957

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 .....  
Signature of Student Embalmer

Signed *Gerald I. Wade*

Licensed Embalmer No. *417*

P. O. Address *Brown*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.