

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016746

STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 317

Primary Registration District No. 547

Registrar's No. 970

300

-57

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1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before) a. STATE Missouri b. COUNTY Cape Girardeau		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Cape Girardeau 0164		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hospital		Length of stay in 1b 5 days	d. STREET ADDRESS (If outside, give location) 1909 College		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Muriel Middle Marie Last Bollinger			4. DATE OF DEATH Month April Day 3 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1924		9. AGE (In years last birthday) 33
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Sedgewickville, Mo. 0		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Lauren V. Conrad		13b. MOTHER'S MAIDEN NAME Namoni Conrad		14. NAME OF HUSBAND OR WIFE Loyd Bollinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 491-30-5507		17. INFORMANT Address Loyd Bollinger, Cape Girardeau, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Middle meningeal hemorrhage.					INTERVAL BETWEEN ONSET AND DEATH 5 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Trigeminal neuralgia 4 yrs.					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____					
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 March 28, 1958 to April 2, 1958 and last saw her alive on April 2, 1958 Death occurred at 6:05 am on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Robert W. Walsh</i> (Degree or title)			22b. ADDRESS 6944 Chippewa Ave.		22c. DATE SIGNED Apr. 4, '58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-3-58	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) Cape Girardeau, Mo.
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. 4-7-58		26. REGISTRAR'S SIGNATURE <i>Herbert B. Donke MD</i>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms when death occurred. All diseases in Part I must be causally related.

State of _____
 Department of Health
 Bureau of Health Services
 License for Embalmer
 No. _____
 Name of Deceased _____
 Date of Death _____
 Date of Embalming _____
 Location of Embalming _____
 Name of Embalmer _____
 License No. _____
 Signature of Embalmer _____
 Date of Signature _____

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