

FILED OCT 31 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035421

STATE FILE NUMBER

Registration District No. 27 Primary Registration District No. 5081 Registrar's No. 144

300  
1-57  
1

1. PLACE OF DEATH a. COUNTY <b>Bates</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Bates</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>East Boone Twp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb <b>72 years</b>		007 STREET ADDRESS <b>East Boone Twp.</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Emmett</b> Last <b>Bolling</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>21</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 1, 1886</b>	9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>20</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Bates Co. Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Benjiman Franklin Bolling</b>			13b. MOTHER'S MAIDEN NAME <b>Mitalda Galloway</b>		14. NAME OF HUSBAND OR WIFE <b>Flora Bolling</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>490-42-5652</b>		17. INFORMANT Address <b>Mrs. Flora Bolling, Adrian, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Heart disease</b>							
DUE TO (c) <b>4201</b>							
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 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.) <b>None</b>				
20c. TIME OF INJURY Hour <b>None</b> a.m. <b></b> p.m. <b></b>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. CITY, TOWN, OR LOCATION <b>Adrian, Mo.</b>		COUNTY <b>Bates</b> STATE <b>Mo.</b>	
21. I attended the deceased from <b>6:30 P.M.</b> to <b></b> and last saw <sup>her</sup> him alive on <b></b> Death occurred at <b>6:30 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Douglas C. Leonard M.D.</b>				22b. ADDRESS <b>Bates, Mo.</b>		22c. DATE SIGNED <b>10/23/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-25-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crescent Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Adrian, Mo.</b>		
24. FUNERAL DIRECTOR <b>Six Funeral Service, Adrian, Mo.</b>			ADDRESS <b>Adrian, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Oct. 25-1958</b>	26. REGISTRAR'S SIGNATURE <b>Kenneth Perry</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 ..... 

Licensed Embalmer No. .... 3650 .....  
P. O. Address Adrian, 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.