

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS NOV 9 1959 **53**

**59-035457**

Registration District No. \_\_\_\_\_ Primary Registration District No. **3009** Registrar's No. **390**

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Bollinger</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jackson</b>		Length of stay in 1b <b>8 Days</b>	c. CITY OR TOWN <b>Sedgewickville</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deal Nursing Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2 miles East</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Marion Columbus Bollinger</b>			4. DATE OF DEATH Month <b>October</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</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>2/20/1887</b>	9. AGE (last birthday) <b>72</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Sedgewickville Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>John Bollinger</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Friese</b>		14. NAME OF HUSBAND OR WIFE <b>Chlole Bollinger</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>None</b>	17. INFORMANT Address <b>Ray Bollinger Jackson Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		<b>16 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis, generalized</b>	<b>2 yrs.</b>
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input 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 **10-15-59** to **10-25-59** and last saw <sup>her</sup>him alive on **10-24-59**  
Death occurred at **6:00 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (In green or title) <b>E.F. McDonald, MD.</b>	22b. ADDRESS <b>Jackson, Mo.</b>	22c. DATE SIGNED <b>10-27-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/27/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sedgewickville</b>	23d. LOCATION (City, town, or county) (State) <b>Sedgewickville Mo.</b>
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24. FUNERAL DIRECTOR <b>McCombs</b>	ADDRESS <b>Jackson, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-2-1959</b>	26. REGISTRAR'S SIGNATURE <b>Jane Kasten</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Bruce Dockins, Student Embalmer No. 598

working under my personal supervision.

Student Bruce Dockins  
Signature of Student Embalmer

Signed BR Meyer

Licensed Embalmer No. 3051

P. O. Address Jackson

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.