

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS/NOV 2 1959

59-038447

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2737 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>IRON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BEL NOR</u>		Length of stay in lb <u>5 yrs</u>	c. CITY OR TOWN <u>ANNAPOLIS MO</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>3008 ARLMONT</u>		Inside limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>3008 ARLMONT</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MATHIMA S. BOLCH</u>			4. DATE OF DEATH Month Day Year <u>OCT. 15 1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 18 1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during AT HOME if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>SABULA MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN S. BENSON</u>		13b. MOTHER'S MAIDEN NAME <u>IDA FARM</u>		14. NAME OF HUSBAND OR WIFE <u>CHARLES E. BOLCH</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>NONE</u>	17. INFORMANT Address <u>Mrs. Geo. Wasinger</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>Coronary occlusion, ST. LOUIS MO</u>	INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>
DUE TO (b) <u>Auricular Fibrillation</u>	<u>5 yrs.</u>
DUE TO (c) <u>Arterio-sclerotic Heart Disease</u>	<u>65 yrs.</u>

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Cerebral thrombosis - 5 yrs

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

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"/> <u>No accident</u>	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		
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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>1955</u> to <u>Oct. 15 1959</u> and last saw her <u>Oct. 12 1959</u> alive on <u>6 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>C. Rush McCadam M.D.</u>		22b. ADDRESS <u>906 0/10 E. ST LOUIS</u>	22c. DATE SIGNED <u>10-16-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-18-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Annapolis Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Annapolis MO</u>
24. FUNERAL DIRECTOR <u>WHITE FUNERAL HOME</u> <u>Equal & White</u>		25. DATE RECD. BY LOCAL REG. <u>10-16-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>

(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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Barcel J White

Licensed Embalmer No. 3012

P. O. Address Proton, Va

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.