

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS NOV 25 1959

59-039245

STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 81

ENDED

|  |   |   |  |   |  |  |   |
|--|---|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Carroll</u>  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u> |  |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Carrollton</u>   |   | Length of stay in 1b<br><u>25 yrs.</u>  |  | c. CITY OR TOWN <u>Carrollton</u>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>603 E. Benton</u>  |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><u>603 E. Benton</u>   |  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>SAM</u> Middle <u>BOLLING</u> Last <u>BOLLING</u>   |   |   |  | 4. DATE OF DEATH<br>Month <u>Nov.</u> Day <u>22</u> Year <u>1959</u>  |  |  |   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>   | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Aug. 11, 1888</u>  | 9. AGE (last birthday) <u>71</u>                       | IF UNDER 1 YEAR<br>Months <u>7</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>  | IF UNDER 24 HR<br>Hours <u>0</u> Min. <u>0</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Pipe Lines</u>   |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Oil</u>                                      | 11. BIRTHPLACE (City and state or country)<br><u>McComb, Miss.</u>  |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U. S. A.</u>   |   |
| 13. FATHER'S NAME<br><u>Samuel Bolling</u>   |   |   | 13. MOTHER'S MAIDEN NAME<br><u>Ruth Amanda Terlow</u>                                |   |  | 14. NAME OF HUSBAND OR WIFE<br><u>Mr. Jas. Brockman</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>  |   |   | 16. SOCIAL SECURITY NO.<br><u>487-10-5155</u>  | 17. INFORMANT<br><u>Mr. Jas. Brockman, Carrollton, Mo.</u>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>   |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 days</u>  |   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 <u>11-16-59</u> to <u>11-22-59</u> and last saw him alive on <u>11-22-59</u><br>Death occurred at <u>2:00 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |   |  |  |   |
| 22a. SIGNATURE (Degree or title)<br><u>Conrad K. Smith D.C.</u>  |   |   |  | 22b. ADDRESS<br><u>107 1/2 W. Carrollton, Mo.</u>   |  | 22c. DATE SIGNED<br><u>11/23/59</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  | 23b. DATE<br><u>11-24-59</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gloster Cem.</u>   |  | 23d. LOCATION (City, town, or county)<br><u>Gloster, Miss.</u>  |  |  |   |
| 24. FUNERAL DIRECTOR<br><u>Gibson Funeral Home, Carrollton, Mo.</u>  |   |   | ADDRESS  | 25. DATE RECD. BY LOCAL REG.<br><u>11-24-59</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Mr. Herbert Carmel</u> |  |   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 28 1961 SA

**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 Ben W Gibson

Licensed Embalmer No. 2961  
P. O. Address Carrollton W

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.