

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-025042
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3296

FILED JUL 20 1961

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY	Length of stay in 1b 34 YEARS	c. CITY OR TOWN KANSAS CITY	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BAPTIST MEMORIAL HOSP.		d. STREET ADDRESS 1010 EAST 43rd Street	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last ANNABELLE BELLE BOLANDER			4. DATE OF DEATH Month Day Year JULY 1st 1961		
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-15-92	9. AGE (last birthday) 69	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - SEAMSTRESS		10b. KIND OF BUSINESS OR INDUSTRY WOOLE BROTHERS DOMESTIC	11. BIRTHPLACE (City and state or country) PARSONS KANSAS	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME OSCAR SRACK		13b. MOTHER'S MAIDEN NAME MIRIAM ROBBINS		14. NAME OF HUSBAND OR WIFE RAY G. BOLANDER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			17. INFORMANT Address K.C.MO RAY G. BOLANDER, 1010 EAST 41st STREET		

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 7 days
IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	
CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.	Arteriosclerosis, cerebral	
DUE TO (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

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 <u>1953</u> to <u>July '61</u> and last saw her alive on <u>July 1961</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Deduce or Title) <i>Wallace H. Graham</i>		22b. ADDRESS 518 Argyle Bldg.		22c. DATE SIGNED 3 July 61	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JULY 3, '61	23c. NAME OF CEMETERY OR CREMATORIUM FLORAL HILLS CEMETERY		23d. LOCATION (City, town, or county) KANSAS CITY MISSOURI	(State)
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS		ADDRESS 137 BRUSH CR. KANSAS CITY MO	25. DATE RECD. BY LOCAL REG. 7-3-61	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>	

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

Wallace H. Graham

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

Vern Lawler

Licensed Embalmer No.

4915

P. O. Address

K. C. 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.