

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-042213

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10831 STATE FILE NUMBER

AMENDED

FILED DEC 12 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>	Length of stay in 1b <u>unknown</u>	c. CITY OR TOWN <u>St. Louis</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>City Hospital</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2330 Olive Street</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>FRANCES</u> Last <u>BOLLMAN</u>	4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1961</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/26/1888</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>Decatur, Indiana</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Robert Bollman</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Denny</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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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. ---	17. INFORMANT <u>423 So. 74th</u> Address <u>East Avenue, Mrs. Charles Parker, Tulsa, Oklahoma</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Fracture of left hip; Arterio sclerosis;

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

DUE TO (b) Suffered in fall in room on or about

DUE TO (c) October 12th 1961.

INTERVAL BETWEEN ONSET AND DEATH

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

904.0-21

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

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>See above</u>
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20c. TIME OF INJURY Hour <u>?</u> a.m. <u>?</u> p.m. <u>?</u>	Month, Day, Year <u>10-12-61</u>
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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.) <u>at home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis, Mo</u>	COUNTY	STATE
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph M. Zuercher Deputy Coroner</u>	22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>11-21-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	23b. DATE <u>11/21/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Missouri Crematory</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
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24. FUNERAL DIRECTOR <u>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave</u>	25. DATE RECD. BY LOCAL REG. <u>NOV 21 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>
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DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

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 Not Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Norman W. Gehler
Funeral Director
Licensed Embalmer No. _____

P. O. Address 3620 Chippe

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.