

on District No. **7-73**Primary Registration District No. **6018A**Registrar's No. **92**

## 1. PLACE OF DEATH:

(a) County **St. Francois**  
 (b) City or town **Farmington, Missouri**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**State Hospital No. 4 9**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **Nine years**  
 (Specify whether years, months or days)  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME **NICK BOLAR**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male**  5. Color or race **W.**  
 6. (a) Single, widowed, married, divorced **Married**  
 6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Unknown**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>71</b>			hr. _____ min.

9. Birthplace **Croatia** **9**  
(City, town, or county) (State or foreign country)10. Usual occupation **Laborer**

11. Industry or business \_\_\_\_\_

12. Name **Unknown**13. Birthplace **9**  
(City, town, or county) (State or foreign country)14. Maiden name **Unknown**15. Birthplace **9**  
(City, town, or county) (State or foreign country)16. (a) Informant **Records State Hospital No 14**(b) Address **Farmington, Missouri**17. (a) **Burial** (b) Date thereof **June 5, 1941**  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **State Hospital No. 4**18. (a) Signature of funeral director **Cozean Undertakers.**(b) Address **Farmington, Missouri**19. (a) **June 5-4** (b) **T. J. Robinson**  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis Co 94**  
 (c) City or town **St. Louis**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **Unknown**  
 (If rural, give location)  
 (e) Citizen of foreign country? **Unknown** (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **3**  
year **1941** hour **5** minute **30** a.m.21. I hereby certify that I attended the deceased from **Nov. 15**  
19**38** to **June 3,** 19**41**;that I last saw him alive on **June 2,** 19**41**;  
and that death occurred on the date and hour stated above.Immediate cause of death **Sero-Fibrinous Peritonitis** **2 days**Due to **Acute Hepatitis** **5 days**Due to **Cholecystitis** **10 yrs**Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: **Cholecystitis**Of operations \_\_\_\_\_  
Of autopsy **Sero-Fibrinous Peritonitis**

## PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_23. Signature **R. Kuhlman** (M. D. or other) **13**  
Address **Farmington Mo** Date signed \_\_\_\_\_

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**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, fact should be so stated above.**

**Not embalmed.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 22583

Registration District No. 993

Primary Registration District No. 6018<sup>a</sup>

Registrar's No. 92

1. PLACE OF DEATH:  
(a) County St. Francois  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME rich Bolan  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death  
Acute Fibrinous Peritonitis 2 da  
Acute Hepatitis 5 da  
Cholecystitis 2 10 yrs  
127a  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Cholecystitis  
no gall stones  
Of autopsy: Acute Fibrinous Peritonitis  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPERINTENDING PHYSICIAN

5-22583

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I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**