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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 5 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

25616

State File No.

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 1644

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison 62

(c) City or town Fredericktown 1
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country //

3. (a) PRINT FULL NAME John Rutherford Bollinger

3. (b) If veteran, name war None

3. (c) Social Security No. none

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married //

6. (b) Name of husband or wife Ellie Bollinger

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Aug. (Month) 29th (Day) 1877 (Year)

8. AGE:

Years	Months	Days	If less than one day
66	11	2	hr. min.

9. Birthplace Sedgewickville (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Andrew Bollinger
13. Birthplace Sedgewickville (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name Ellie Hammond
15. Birthplace Harris Mo. (City, town, or county) 0 (State or foreign country)

16. (a) Informant Paul Bollinger
(b) Address 1561 Lewis Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-4-44 (Month) (Day) (Year)
(c) Place: burial or cremation Fredericktown Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave

19. (a) AUG 3 - 1944 (Date received local registrar) (b) C. D. McGavran, MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 1st year 1944 hour 4.50 minute A. M.

21. I hereby certify that I attended the deceased from July 25, 1944, to Aug 1, 1944 that I last saw him alive on July 31, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Uremia — Duration 30 days

Due to Chron Glom. Nephritis ?yrs?

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 131b

Of autopsy

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

23. Signature R A Lusella (M. D. or other) ✓ C
Address 3720 Washington Date signed 8/1/44

(Licensed Embalmer's Statement on Reverse Side)

NOV 28 1945

AUG 28 1944

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.