

S. No. 2
M-5-43
5-17-39
I X36671

FILED NOV 6 1946

State File No. _____

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 134

1. PLACE OF DEATH:

(a) County C lay

(b) City or town Excelsior Springs, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Vet. Adm. Hosp., Excelsior Springs, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 days (Specify whether years, months or days)

In this community 19 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME BOLIN, Samuel

3. (b) If veteran, name war World war I

3. (c) Social Security No. None

4. Sex Male 5. Color or White

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

6. (b) Name of husband or wife -- 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased Oct. 16, 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

59 0 0 hr. min.

9. Birthplace Stillwell, Okla.
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Farming

MOTHER FATHER

12. Name Martin Bolin

13. Birthplace Stillwell Okla.
(City, town, or county) (State or foreign country)

14. Maiden name Annie Walker

15. Birthplace Stillwell Okla.
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital records, Vet. Adm. Hosp.

(b) Address Excelsior Springs, Mo.

17. (a) Removal (b) Date thereof 10-17-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: of removal: Marble City, Oklahoma

18. (a) Signature of funeral director HOPE FUNERAL HOME
Excelsior Springs, Mo.

(b) Address

19. (a) 10/20/46 (b) Baseline Hutchings
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Oklahoma (b) County Sequoyah

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

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 16
year 1946 hour 1 minute 00 P. M.

21. I hereby certify that I attended the deceased from Sept. 28
1946 to Oct. 16 1946

that I last saw him alive on Oct. 16 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Abscess, multiple, tuberculous,
chest and lower trunk unknown

~~DETOX~~

Tuberculosis, chronic, of sacroiliac
joint, left unknown

Other conditions: Multiple draining sinuses,
tuberculous, chest and lower trunk Unknown

Major findings:
Of operations _____

Of autopsy No autopsy performed 138

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. H. Kaplan (M. D. or other) MD
Address Veterans Administration Date signed 10-16-46

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

31821

62

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 11-2-46

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

James A. Moles

Licensed Embalmer No.

3296

P. O. Address

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