

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38687

FILED OCT 16 1957

Registration District No. 807 Primary Registration District No. 500 Registrar's No. 2351

STATE FILE NUMBER

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST JOHN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>ST ANN 4070</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>ROUGH MANOR REST HOME 8 1/2 MO.S</u> Length of stay in 1b | | d. STREET ADDRESS <u>3944 WRIGHT</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>EMILY</u> ^{First} <u>ELLEN</u> ^{Middle} <u>BOLEND</u> ^{Last} | | 4. DATE OF DEATH - <u>9-22-57</u> Month Day Year | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-3-1869</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u> | | 9b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | 9c. AGE (In years) <u>88</u> (If birthday) IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | 11. BIRTHPLACE (City and state or country) <u>MINNITH MISSOURI, U.S.A.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>NICHOLAS RIMBOCH</u> | |
| 14. MOTHER'S MAIDEN NAME <u>FRANCES NANEY</u> | | 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. <u>NONE</u> | | 17. INFORMANT <u>ETHAN ALLEN 3930 ASHBYRD ST ANN MO</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Atherosclerosis - general</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a. m. p. m. | |
| 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.) | |
| 20f. CITY, TOWN, OR LOCATION | | 20g. COUNTY | |
| 20h. STATE | | 21. I attended the deceased from <u>Sept 3, 1926</u> to <u>Sept 22, 1957</u> and last saw her alive on <u>Sept 21, 1957</u> Death occurred at <u>1:45 am</u> on the date stated above; and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE <u>Joseph E. Carney MD</u> (Degree or title) | | 22b. ADDRESS <u>906 Olive</u> | |
| 22c. DATE SIGNED <u>9-23-57</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | |
| 23b. DATE <u>9-25-57</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>MINNITH CEMETERY</u> | |
| 23d. LOCATION (City, town, or county) <u>MINNITH</u> | | 23e. (State) <u>MO.</u> | |
| 24. FUNERAL DIRECTOR <u>EARL HILLOMAN OVERLAND, MO.</u> ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>9-23-57</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Herbert R. Dombke MD</u> | | | |

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Services

300 4564

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Carl E. Hillman*

Licensed Embalmer No. *3501*

P. O. Address *Orland 14*

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.