

FILED MAY 4 1945

Registration District No. **223**

Primary Registration District No. **5795**

Registrar's No. **8**

1. PLACE OF DEATH:

(a) County Moniteau
(b) City or town California
(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 64 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Moniteau
(c) City or town Rural Pilot Springs
(If outside city or town limits, write "RURAL")
(d) Street No. 6 mile south West California Mo.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

ANNA BELL BOLINGER

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

4. Sex F 1 | 5. Color or race W | 6. (a) Single, widowed, married | divorced Married

6. (b) Name of husband or wife John Henry Bolinger | 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased July 7 1882
(Month) (Day) (Year)

8. AGE: Years 62 Months 8 Days 28 | If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Jane B. Allen

13. Birthplace Moniteau Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Barbara Ann Scott

15. Birthplace Moniteau Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Melan Miller
(b) Address California Mo.

17. (a) Flag Spring Cem. (b) Date thereof 7-5-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flag Spring, Moniteau
18. (a) Signature of funeral director High & William
(b) Address California Mo.
19. (a) 4-5-1945 (b) Mrs. H. J. Sullivan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4
year 1945 hour 8 minute A.M.
21. I hereby certify that I attended the deceased from Feb 2
1945 to April 4 1945
that I last saw her alive on April 1 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Nephritis
Chronic Myocarditis

Duration
2 year
2 year

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature George Latham (M. D. or other) _____
Address California, Mo. Date signed 4-5-45

MOTHER FATHER

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

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 5-2-45

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 Hugh L. E. Williams
Licensed Embalmer No. 3537

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.

Registration District No. 223 Primary Registration District No. (5795)

1. PLACE OF DEATH:
(a) County Monteau
(b) City or town (New California, Mo)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Rural Pilot Grove Twp
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Monteau
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. Rural near California
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Anna Bell Bolinger
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 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: July (Month) 19 (Day) 19 (Year)
8. AGE: Years 62 Months 8 Days _____ If less than one day _____ min.

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
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)

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) Mrs H. J. Sullivan (Date received local registrar) (Registrar's signature)

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) (c) Means of injury _____
23. Signature _____ (M. D. or other) _____
Date signed _____

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

SUPPLEMENTAL

MOTHER FATHER

14015

②

1941

1942