

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0047177

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 336

Primary Registration District No. 4494

Registrar's No. NS

STATE FILE NUMBER

REFILED 08 64

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
Rev. 4/59		
1 1010		
2 1010		
3		
4 /		
5 /		
6		
7 /		
8 0		
9 17ix		
10		
11		
12 9p-0	INSTEAD OF	
13 1-0		
	DOCUMENT	BY AFFIDAVIT OF
	MEDICAL CERTIFICATION	SHOULD READ
	BY AFFIDAVIT OF	SHOULD READ
	MEDICAL CERTIFICATION	SHOULD READ
	BY AFFIDAVIT OF	SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Shannon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Winona</u>		c. CITY OR TOWN <u>Winona</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Ellen</u> Last <u>Bolin</u>		4. DATE OF DEATH <u>November 30, 1964</u> Month <u>November</u> Day <u>30</u> Year <u>1964</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/5/78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>86</u>
11. BIRTHPLACE (City and state or country) <u>Jamestown, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Livingston</u>		13b. MOTHER'S MAIDEN NAME <u>Jan ?</u>	14. NAME OF HUSBAND OR WIFE <u>George D. Bolin</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>Goldie Hough</u> Address <u>Winona, Mo.</u>
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>CARCINOMA OF THE CERVIX</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>OCT-1-64</u> to <u>NOV 24</u> and last saw her alive on <u>11/29-64</u> Death occurred at <u>Winona, Mo.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>N. A. Collins</u> (Degree or title)		22b. ADDRESS <u>Winona, Mo.</u>	22c. DATE SIGNED <u>12/4-64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/2/64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cem.</u>	23d. LOCATION (City, town, or county) State <u>Winona, Missouri</u>
24. FUNERAL DIRECTOR'S ADDRESS <u>Duncan Funeral Home Mtn. View, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-7-64</u>	26. REGISTRAR'S SIGNATURE <u>Mobile Rogers</u>

AUG 31 1966

1

DEC 11 1966

DEC 22 1964

Beard (in med)

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 Charles D. Partain

Licensed Embalmer No. 5107

P. O. Address W. H. Miller, MD

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.