

STATE OF FLORIDA
BUREAU OF VITAL STATISTICS

De Schell
 File No. _____

1 PLACE OF DEATH

STATE BOARD OF HEALTH

File No. _____

County _____

CERTIFICATE OF DEATH

Registered No. _____

Precinct _____

Registration District No. _____

[If death occurred
 in a hospital or in-
 stitution, give its
 NAME instead of
 street and number]

(Write name, not number)

or
 Inc. Town _____

Primary Registration Dist. No. _____

or
 City _____

(No. *514 W Church* St.; _____ Ward)

2 FULL NAME *Walter B. Bolder*

(a) Residence No. *514 W Church* St., _____ Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX _____ 4 COLOR OR RACE _____ 5 Single, Married, Widowed, or Divorced *Single* Write the word

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH *Aug 17 - 1884* 1 _____ (Month) (Day) (Year)

7 AGE *38* yrs. mos. ds. IF LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *Laborer* (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) *Tex* (State or country)

10 NAME OF FATHER *Stephen Bolder*

11 BIRTHPLACE OF FATHER (City or Town) _____ (State or country)

12 MAIDEN NAME OF MOTHER *P. Williams*

13 BIRTHPLACE OF MOTHER (City or Town) _____ (State or country)

14 Informant *C. H. Bolder* (Address)

15 Filed _____ 192 *738 W Church* Form V. S. No. 4 Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day and year) *7/29/30* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

 _____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____ (Signed) _____ M. D.

19 _____ (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 Place of Burial, Cremation, or Removal *Emergreen Cemetery* Date of Burial or Removal *8/1* 19 *22*

20 UNDERTAKER _____ ADDRESS _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated.

Mother Row 4
2 sists - Pine Hall
+ 1 on M

Day spring

4709