OCT 31 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

30863

File No.
Registered No. 403

1. PLACE OF DEATH

County Randolph — Registration District No. 735
Township — Primary Registration District No. 3034
City Moberly (No. Wabash Hospital St. Ward)

2. FULL NAME Stephen A. Tulk

(a) Residence. No. St., Ward. Bloomfield, Ia
(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 (write the word)
male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 17th 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	62	10	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Water Service
(b) General nature of industry, business, or establishment in which employed (or employer) Wabash R.R.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Ia

PARENTS
10. NAME OF FATHER Benjamin Tulk
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Priscella Moss
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ind.

14. INFORMANT W. M. Tulk
(Address) Horton, Kas

15. FILED 9-8 1930 Dr. Thos. J. Fleming REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 8th 1930

17. I HEREBY CERTIFY, That I attended deceased from January 3, 1930, to September 8, 1930 that I last saw him alive on September 8, 1930, and that death occurred, on the date stated above, at 7:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pernicious anemia — Terminal
CONTRIBUTORY (duration) 5 yrs. mos. ds.
(SECONDARY) Broncho-pneumonia 4 days
Right Hemiplegia (duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory
(Signed) Max E. Kaiser, M. D.
9-8th, 1930 (Address) Wabash Hospital.

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Bloomfield, Iowa	9-10th 1930
20. UNDERTAKER	**ADDRESS**
Mahan and Son	Moberly Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.