DEC 22 1930

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

Do not use this space.

36465

File No. .....

Registered No. 157

1. PLACE OF DEATH

County Jackson Registration District No. 4003

Township ~~Kansas City~~ Primary Registration District No. 4205

City Lee's Summit Inc. ..... St. ..... Ward)

2. FULL NAME Rachel Ann Bullard

(a) Residence. No. Lee's Summit Mo Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ~~7~~ yrs. 2 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)
Female	White	Widowed

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Geo Bullard

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 1-1856

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7~~3~~/4	8	24	

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

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

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Elizabeth A. Turner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky
(STATE OR COUNTRY)

14. INFORMANT Mrs Annie Coy
(Address) Lee's Summit

15. FILED Nov 30 1930 J. L. Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-25 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23 1930, to Nov. 25 1930, that I last saw ..... alive on Nov. 22 1930, and that death occurred, on the date stated above, at 6 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Nephritis

(duration) 4 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED Chilhowee Mo
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS Symptoms

(Signed) J. Maddale, M. D
11-26 1930 (Address) Lee's Summit Mo

*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 Chilhowee Mo — DATE OF BURIAL Nov 27 1930

20. UNDERTAKER J. W. Goodman — ADDRESS Holden 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT