

SEP 21 1937

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

Do not use this space.

31314

1. PLACE OF DEATH

County *New Madrid*
Township *Corno*
City (No.)

Registration District No. *605*
Primary Registration District No. *4559*

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Sherman Grant Hull

(a) Residence, No. _____ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug. 1 1937*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Lillie May Hull*

22. I HEREBY CERTIFY, That I attended deceased from *Aug. 1 1937* to *Aug. 1 1937*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *3-5-1867*

I last saw him alive on *about July 15 1937*. Death is said to have occurred on the date stated above, at *7 A* m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *70 4 26*

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Pharmacist*

Multiply Adeno Date of onset _____

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *and Farmer*

(Carcinoma) *about 8/1/36*

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Other contributory causes of importance: *5*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Napella Ill.*

13. NAME *J. G. Hull*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Waynesville Ill.*

15. MAIDEN NAME *Adaline Harrold*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Waynesville Ill.*

17. INFORMANT *Adaline Hull* (ADDRESS) *Rivers no.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvin Ill.* DATE *8-3-1937*

19. UNDERTAKER *St. Louis* (ADDRESS) *no.*

20. FILED *8-2-* 1937 *Dr. Geo. Huat* Registrar.

Name of operation *no* Date of _____
What test confirmed diagnosis *laboratory* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *no*
If so, specify _____

(Signed) *James Beal* M. D.
(Address) *Malden Mo*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

53

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 605-
(b) Township Como Primary Registration District No. 455-9 Registered No. _____
(c) City _____ (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Sheridan Grant Hull
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 1 1937

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. _____ alive on _____, 19____. Death is said

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 4 26

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation _____

Multiple Adeno Carcinoma

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance: Prostate 51

FATHER 13. NAME

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS)

Manner of injury _____

Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Homer Beall, M. D.

(Address) Malden Mo

20. FILED 10/30 1937 D. G. Hutchins Local Registrar.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-31314