

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38631**
Registrar's No. **4395**

DEC 11 1939 399
Registration District No. _____

Primary Registration District No. 1002

1. PLACE OF DEATH: **2**

(a) County Jackson

(b) City or town Kansas city

(c) Name of hospital or institution 1109 Charlotte
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 15 days
(Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: **2**

(a) State Arkansas (b) County Poinsette

(c) City or town Marked Tree
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. 7. _____ years.

8. (a) PRINT FULL NAME Nettie Mules **425**

3. (b) If veteran, name war No 3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 14
year 1939 hour 10-5 minute A.M.

4. Sex Female 5. Color or race colored (a) Single, widowed, married, divorced, widow

6. (b) Name of husband or wife Bryant Mules 6. (c) Age of husband or wife if alive dead years

7. Birth date of deceased 10-18-68
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 14, 1939, to Nov 14, 1939
that I last saw her alive on Nov 14, 1939
and that death occurred on the date and hour stated above.

8. AGE: Years 71 Months 1 Days 4 If less than one day hr. _____ min. _____

Immediate cause of death Cerebral Hemorrhage Duration 4 hrs

Due to GPV

Due to _____

9. Birthplace Ala.
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

11. Industry or business none

12. Name Martin Bankhead

13. Birthplace Ala
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy none

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Williestine Mules

(b) Address 1109 Charlotte St

17. (a) burial (b) Date thereof 11-18-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marked Tree, Ark.

18. (a) Signature of funeral director J. D. Moore

(b) Address 1920 E-19th Ave. Mo

19. (a) Nov 17 1939 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. Lon M. Tillman (M. D. or other) M. D.
Address 1618 Jy dia Date signed 11/16/39

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed J. B. Moore

Licensed Embalmer No. 2410

P. O. Address Kansas City, Miss.

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 this body is not embalmed, above space should be left blank.