

Registration District No. **6449**

Primary Registration District No. **6225**

Registrar's No. **5**

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Barre Springs Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days 2 1/2

3. (a) PRINT FULL NAME NELTIE BULLBANK

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased March 1 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				<u>5</u> hr. <u>20</u> min.

9. Birthplace Mo (City, town, or county) (State or foreign country) 0

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Anson Bullbank
13. Birthplace Mo (City, town, or county) (State or foreign country) 0
14. Maiden name Chas. Sawyer
15. Birthplace Mo (City, town, or county) (State or foreign country) 0

16. (a) Informant's own signature J. V. Hough
(b) Address Barre Springs Mo

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 3 3 40 (Month) (Day) (Year)
(c) Place: burial or cremation Barre Springs Mo

18. (a) Signature of funeral director R. M. Sawyer
(b) Address Barre Springs Mo

19. (a) March 1 1940 (Date received local registrar) (b) J. V. Hough (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wright
(c) City or town Barre Springs Mo (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. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mo day 15 year 1940 hour 6 minute 7 M.

21. I hereby certify that I attended the deceased from March 1, 1940 to March 1, 1940 that I last saw her alive on March 1, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cremotives
73 months
Due to pregnancy
Due to 15A

Other conditions (Include pregnancy within 3 months of death) Chas. Hough
Major findings: Of operations
Of autopsy _____

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? _____
(Specify type of place) _____
(e) Means of injury _____
23. Signature _____ (M. D. or other)
Address _____ Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically

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.

16-17-30 I X1951

RECEIVED

District Health Officer No. 6,

District File Number-----

Date Filed APR 18 1940-----

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-----

Licensed Embalmer No.-----

P. O. Address-----

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12802

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 949

Primary Registration District No. 6225

Registrar's No. 5

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

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Zenton T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME

Nellie Buttrick

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7

5. Color or race W

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

5 hr 20 min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____

(b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-17-48

(Date received local registrar)

C. H. Howell
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 1
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____; that I last saw him alive on _____, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature C. H. Howell Registrar (M. D. or other)

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

