FILED JUN 10 1940

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

17904
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan Registration District No. 85
(b) Township Primary Registration District No. 1001 Registered No. 548
(c) City St Joseph (d) Street No. St Joseph's Hospital St.
(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 37 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 4TD Alma Charlotte Hull
(a) Residence, No. 305 Hammond St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF C. D. Hull
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 19 1875
7. AGE Years 64 Months 8 Days 24 If LESS than 1 day, ...hrs. or ....min.

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

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

FATHER
13. NAME August Johnston
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stockholm Sweeden

MOTHER
15. MAIDEN NAME Matilda Bergwell
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stockholm Sweeden

17. INFORMANT (ADDRESS) Mrs. W. E. Lawrence 305 Hammond St. Joseph
18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE May 15 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Fleeman & Son, Inc. St. Joseph, Mo.
20. FILED May 15 1940 H. J. Nestlebush Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 13, 1940
22. I HEREBY CERTIFY, That I attended deceased from April 15 1940, to May 13, 1940
I last saw her alive on May 12, 1940 Death is said to have occurred on the date stated above, at 150A m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cancer of the rectum	[illegible]

Other contributory causes of importance: none

Name of operation Proctectomy Date of April 15 1940
What test confirmed diagnosis? Laboratory & clinical 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) John J. Byrne, M. D.
85 (Address) St Joseph Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

I X14028

49

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. 4082

P. O. Address St Joseph

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.

S. No. 2B
—2-21-40
I X22659

MOORE

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17904

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 548

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph (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 years, months or days)

In this community

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.

3. (a) PRINT FULL NAME Alma Charlotte Hull

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 wid

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 64 Months 8 Days 24 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) July 9 1940 (Date received local registrar) (b) H. J. Nesthebust (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13 year 1940 hour minute M.

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

Immediate cause of death Cancer of the Rectum

Due to 46

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Proctectomy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 John J Byrnes (M. D. or other)

Address St Joseph Mo Date signed

S-17904