

STANDARD CERTIFICATE OF DEATH

State File No. 21489Registration District No. 177Primary Registration District No. 5246

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Chariton
 (b) City or town Rural Bea Branch Twp. 2
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
R. F. D. #2 near Leon Mo.
 (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 William Jasper Hullett. 4303. (b) If veteran, name was None 3. (c) Social Security No. None4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Mary Thomas 6. (c) Age of husband or wife if alive Unknown years7. Birth date of deceased May 21, 1867
(Month) (Day) (Year)8. AGE: Years 73 Months 0 Days 0 If less than one day _____ hr. _____ min.9. Birthplace Chariton County
(City, town, or county) (State or foreign country)10. Usual occupation Retired Farmer 011. Industry or business _____ 012. Name Phoebe Newton Hullett 013. Birthplace Missouri 0
(City, town, or county) (State or foreign country)14. Maiden name Phoebe Thomas15. Birthplace Missouri
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Mary Hullett(b) Address New Cambria, Mo. R. F. D. #217. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/40
(Month) (Day) (Year)(c) Place: burial or cremation New Cambria Cem.18. (a) Signature of funeral director Albert Skinner.(b) Address Leon, Mo.

19. (a) _____ (b) _____

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Chariton
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1/2 mile south Leon, Mo.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21
year 1940 hour 5 minute 20 A.M.21. I hereby certify that I attended the deceased from May 17, 1940 to May 21, 1940
that I last saw him alive on May 20, 1940
and that death occurred on the date and hour stated above.Immediate cause of death _____ Duration 1 weekDue to ApoplexyDue to Hypertensive Heart DiseaseDue to ArteriosclerosisOther conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____

Of autopsy _____

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? 163

23. Signature _____ (Specify type of place) _____
While at work? _____ (a) Means of injury _____23. Signature G. L. Skinner, M.D. or other
Address Callao Mo Date signed 4/6/40

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. 21489
Registrar's No. 42

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 178

Primary Registration District No. 5246

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

1. PLACE OF DEATH:
(a) County Chariton
(b) City or town Bea Branch TWP.
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Wm Jasper Hullett
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color of race w
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year
7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 73 Months 0 Days 0 If less than one day _____ hr _____ 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 _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-1-40 _____ (Date received local registrar) _____ (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

19. MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 21
year _____ 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 _____
Due to _____
Due to _____

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

Of autopsy _____
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? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____
23. Signature J. L. Durdene _____ (M. D. or other) _____
Address Callao _____ Date signed _____

SUPPLEMENTAL

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The