

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

25026
Do not use this space.

1. PLACE OF DEATH
 (a) County Dallas Registration District No. 241
 (b) Township N. Benton Primary Registration District No. 5-3-24
 (c) City _____ (d) Street No. _____ 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Henry Lull
 (a) Residence, No. 400 Long Lane, Mo. O 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

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 11, 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 7 21

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wood Co. Ohio

FATHER
 13. NAME Unknown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

MOTHER
 15. MAIDEN NAME 9
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

17. INFORMANT Sam Lull
 (ADDRESS) Buffalo Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Union Home DATE 6-2-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) L. B. Jones
Buffalo Mo.

20. FILED 8-14-1940 Harvey Morrow
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-1-1940

22. I HEREBY CERTIFY, That I attended deceased from 8:27 1940 to 6-1 1940
 I last saw him alive on 8-31 1940 Death is said to have occurred on the date stated above, at 4:30 p.m.
 The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage
 Date of onset 87W

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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?
 If so, specify no
 (Signed) W. H. Remond, M. D.
 (Address) Buffalo Mo.

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.

RECEIVED

District Health Officer No. 7,

District File Number 8-40-1227

Date Filed 8-10-40

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.