

D. 2
3-40
7-39
K23159

Registration District No. 85

Primary Registration District No. 1001

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

1. PLACE OF DEATH:

(a) County BUCHANAN

(b) City or town ST. JOSEPH

(c) Name of hospital or institution: STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 yrs 3 mo 26 da
(Specify whether years, months or days)

In this community 3
years, months or days

3. (a) PRINT FULL NAME ESTELLA BESSIE McCULLOUGH

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased May 8 1895
(Month) (Day) (Year)

8. AGE: Years 45 Months 6 Days 21 or _____ min.

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

10. Usual occupation Stenographer

11. Industry or business _____

12. Name John McCullough

13. Birthplace Dearborn Co. Ind.
(City, town, or county) (State or foreign country)

14. Maiden name Blaise Carmichael

15. Birthplace Dearborn Co. Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address State Hosp #2 St. Joseph, Mo.

17. (a) Burial (b) Date thereof 12-2-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation State Hospital Cemetery

18. (a) Signature of funeral director Walter Meischer

(b) Address 1302 Targow Street

19. (a) 12-3-1940 (b) H. Hestlebach
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Independence
(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 Nov. day 29
year 1940 hour 2 minute 00 P. M.

21. I hereby certify that I attended the deceased from July 1, 1940 to Nov. 29, 1940;
that I last saw her alive on Nov. 29, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis 5 yrs.

Due to _____

Due to _____

Other conditions Dementia Praecox 13 yrs.
(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? 85
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Kenneth Thompson M. D. Mo.
Address State Hosp #2 St. Joseph, Mo. Date signed 11-29-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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, fact should be so stated above.