

No. 2
-4-41
17-39
X26390

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

5911

State File No. _____

683

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C.M. O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution life (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 6019 N. John
(If rural, give location)
(e) Citizen of foreign country? C (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 14 year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from 4:35 PM to _____ 19____
that I last saw _____ survive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Subdural hematoma (rt)
Encephalomalacia
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy Yes

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) DO NOT KNOW
(b) Date of occurrence Admitted Hosp 12-31-40
(c) Where did injury occur? DO NOT KNOW (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 work)
23. Signature Walter H. Mattern (M.D. or other)
Address K.C. Mo. Date signed _____

3. (a) PRINT FULL NAME MARY PULLINS
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Geo E Pullins 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 17-1917
(Month) (Day) (Year)

8. AGE: Years 23 Months 1 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Franklin A. Bucklunger
13. Birthplace Shoshone
(City, town, or county) (State or foreign country)
14. Maiden name Eva Lender
15. Birthplace Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Geo Pullins
(b) Address 6019 N. John

17. (a) Burial (b) Date thereof 2/17/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation NW Washington

18. (a) Signature of funeral director W H Mattern
(b) Address K.C. Mo

19. (a) 7/16/41 (b) W. M. Brown
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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 *John B. Coyle*
Licensed Embalmer No. 3754
P. O. Address 1500

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 683

1. PLACE OF DEATH:

(a) County Jackson
Kenbas City
(b) City or town. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital
(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 Mary Pullins

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Married
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 year
23 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address 2/16/41
19. (a) (Date received local registrar) (b) M. M. Browe (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. 6019 St. John (If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

NEEDLE CERTIFICATION

20. DATE OF DEATH Month Feb. day 14th
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from Deputy Coroner 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
Subdural hematoma (non-traumatic)
Encephalomalacia
Due to
Due to 83a
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Yes

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 Admitted Hosp. 12-31-40
(c) Where did injury occur? Do (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) (c) Means of injury

23. Signature Victor B. Buhler (M. D. or other)
Address Date signed

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

SUPPLEMENTARY

S-5911