DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 14 1942

Registration District No. 1

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

29629

State File No.

Primary Registration District No. 3000

Registrar's No. 252

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

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Kirksville Community Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 24 days (specify whether years, months or days)
In this community —

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County LINN
(c) City or town MARCELINE Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 223 W. WALKER
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME FRANK ELLSWORTH BULEN
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MARY E. BULEN
6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased Oct (Month) 10 (Day) 1863 (Year)

8. AGE: Years 78 Months 11 Days 21 If less than one day 15 hr. 50 min.

9. Birthplace Columbus (City, town, or county) OHIO (State or foreign country)
10. Usual occupation FARMER + MINER
11. Industry or business —
MOTHER FATHER
12. Name TOBIAS BULEN
13. Birthplace — (City, town, or county) CANADA (State or foreign country)
14. Maiden name LEAH JANE ~~BULEN~~ PAINTER
15. Birthplace CHILLICOTHE (City, town, or county) ~~[illegible]~~ OHIO (State or foreign country)
16. (a) Informant HAROLD E. BULEN
(b) Address MACON, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3-1942 (Month) (Day) (Year)
(c) Place: burial or cremation Marceline Mo
18. (a) Signature of funeral director James McLaughlin
(b) Address Marceline Mo
19. (a) Oct. 2, 1942 (Date received local registrar) Mrs. J. L. Wagner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1 year 1942 hour 3 minute 50 P.M.
21. I hereby certify that I attended the deceased from Sept. 7, 1942 to Oct 1, 1942 that I last saw him alive on Oct 1, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac Failure	
Due to Hypostatic Pneumonia	
Due to	
Other conditions FRACTURED HIP (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) 058
(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 Esther P. Barney (M. D. or other) D.O.
Address Kirksville, Mo Date signed 10/1/42

N T

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-42-1872
Date Filed OCT 12 1942

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 Dale Burch

Licensed Embalmer No. 4088

P. O. Address Marceline Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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-21-41
I X29288

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STANDARD CERTIFICATE OF DEATH

State File No. 29629

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 252

1. PLACE OF DEATH:

(a) County Adair

(b) City or town (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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Frank E. Burlen

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or 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 years

7. Birth date of deceased Oct (Month) 10 (Day) 18 (Year)

8. AGE: Years	Months	Days	If less than one day
78	11	21	hr. 0 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 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 Cardiac Failure

Due to Hypostatic Pneumonia

Due to

Other conditions Fractured Hip (Include pregnancy within 3 months of death)

Major findings:
Of operations 186a
Of autopsy 18

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) accident

(b) Date of occurrence 9/4/42

(c) Where did injury occur? Marcline (City or town), Lynn (County) Mo. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Spontaneous fracture occurring in the process of getting out of Bed (Specify type of place)

While at work? (e) Means of injury

23. Signature Esther P. Barney (M. D. or other) D.O.

Address Kirksville, Mo. Date signed

SUPPLEMENTARY