

No. 2
-5-42
-17-39

DEPARTMENT OF COMMERCE 1943
BUREAU OF THE CENSUS
FILE - JAN 26

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1152

State File No.

Registrar's No. 131

Registration District No. 149

Primary Registration District No. 1002

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:
117 North Askew
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether
In this community 6 Years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 117 North Askew
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Mary A. Hulen

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Henry T. Hulen

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

7. Birth date of deceased 8 -8- 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

80 5 3 hr. min.

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

10. Usual occupation At Home

11. Industry or business.....

MOTHER FATHER { 12. Name Andrew J. Roberts

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth

15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W.S. Rising

(b) Address 117 North Askew

17. (a) Removal (b) Date thereof 1-11-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Mo.

18. (a) Signature of funeral director Mrs. G. S. Forst

(b) Address 918 Brooklyn, K.C. Mo.

19. (a) 1/11/43 (b) M. M. Crome
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 11th.
year 1943 hour 9 minute A. M.

21. I hereby certify that I attended the deceased from
Jan 9 1943 to Jan 10 1943
that I last saw her alive on Jan 10 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial
Terminal pneumonia
Myocardial insufficiency
Due to Malnutrition +
avitaminosis
Chronic colitis
Achlorhydria
Other conditions Chronic hypertrophic
(Include pregnancy within 3 months of death) arthritis

Duration

1 day

2 days

years

years

11

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: Decubitus ulcers.

Of operations.....

Of autopsy No autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) N.P.

(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 Jessie Rising (M. D. or other) M.D.
Address 1103 Grand Ave K.C. Date signed 1-11-43

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

Dr. Rising Be 3990

Will come by and sign call him if he is not here by 6 P.M.

STATEMENT BY LICENSED EMBALMER

me

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 *Alan Sheppard*

Licensed Embalmer No. *4179*

P. O. Address *H. C. Pro.*

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.