

S. No. 2
M-2-43
5-17-40
I. X. 1940

24342

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 689
770

FILED AUG 5 1943 42

Registration District No. _____ Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2421 Francis St
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution _____ (Specify whether)
In this community 50 Years (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2421 Francis St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Laura A. Bullock

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 Widowed
6. (b) Name of husband or wife Frank Bullock 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 8 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 2 13 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas Baker

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

14. Maiden name Sarrah Miller
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs Myrtle Osborn

(b) Address Kansas City, Kans.

17. (a) Burial (b) Date thereof 6-23-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Fleeman & Son Inc.

(b) Address 1946 Colhoun St.
19. (a) 6-23-43 (b) Rose Heygo
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21st
year 1943 hour 5 minute 50 P M.

21. I hereby certify that I attended the deceased from June 1, 43
19 43 to June 21, 1943
that I last saw h^e alive on June 14 19 43
and that death occurred on the date and hour stated above

Immediate cause of death Chronic Nephritis Duration _____

Due to _____
Due to _____

Other conditions (Include present within 3 months of death) Myocarditis

Major findings: Of operations _____
Of autopsy No

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 _____

(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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. W. Mays (M. D. or _____)
Address 208 E. 1st St. Date signed 6/23/43

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 Robert H. Gable

Licensed Embalmer No. 3308

P. O. Address. St. Joseph, MO

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.