

No. 2
9-4-41
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 18 1943

Registration District No. 239

Primary Registration District No. 5855 4356

Registrar's No. 4354

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

1. PLACE OF DEATH: New Madrid
 (a) County Parma
 (b) City or town Parma
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: None
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 13 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County New Madrid
 (c) City or town Parma 72
 (If outside city or town limits, write "RURAL") 5
 (d) Street No. _____ (If rural, give location) 6
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME FERDINAND WILLIAM BULTMANN

MEDICAL CERTIFICATION

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

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Hattie Bultmann 6. (c) Age of husband or wife if alive 69 years
 7. Birth date of deceased Feb 25 1872
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____ that I last saw h_____ alive on _____, 19____ and that death occurred on the date and hour stated above

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>4</u>	<u>20</u>	hr. _____ min.

Immediate cause of death Sudden
Cerebral thrombosis
fatal bleed from
 Due to aneurysm

9. Birthplace Proquois County, Illinois (City, town, or county) (State or foreign country)

Due to _____
 Other conditions (Include pregnancy within 3 months of death) 830
 Major findings: Of operations _____
 Of autopsy _____

10. Usual occupation Retired farmer

11. Industry or business _____
 12. Name Henry Bultmann
 13. Birthplace Hohoven, Germany (City, town, or county) (State or foreign country) 4
 14. Maiden name unknown
 15. Birthplace unknown (City, town, or county) (State or foreign country) 9

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? _____

16. (a) Informant Edwin Bultmann

(b) Address Carrollton Mo.

17. (a) Burial (b) Date thereof July 21-43 (Month) (Day) (Year)

(c) Place: burial or cremation Carrollton Mo.

18. (a) Signature of funeral director Walter J. Swain
(b) Address Parma Mo.

23. Signature W. J. Swain (M. D. or other) MD
 Address Parma Mo Date signed 7/21/43
 While at work? _____ (Specify type of place)
 (c) Means of injury _____

19. (a) Aug 5 1943 (b) Drs. S. D. Rademaker (Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

1028

RECEIVED

District Health Office No. **2,**

District File Number 843-1041

Date Filed 8-13-48

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 Hunter Albritton

Licensed Embalmer No. 4210

P. O. Address Sixteen 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28851
Registrar's No. 4356

Registration District No. 289

Primary Registration District No. 4356

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Parma
(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) 13 yrs

3. (a) PRINT FULL NAME Ferdinand W. Bultman
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 Feb 29 (Month) (Day) (Year)

8. AGE: Years 71 Months _____ Days _____ (If less than one day, min.)
9. Birthplace Ill (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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (Date received local registrar) (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. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1991 Hour _____ Minute 30 P.M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions (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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature [Signature] (M. D. or other) [Signature]
Address Parma Mo Date signed _____

SUPPLEMENTARY

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

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

