

FILED OCT 13 1943

Registration District No. **189**

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 **Research Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **20 Days** (Specify whether years, months or days)
In this community **40 yrs.**

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. **6040 East 14th Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **-----**

3. (a) PRINT FULL NAME **Mr. Ray S. Hulén**

3. (b) If veteran, name war **no**
3. (c) Social Security No. **487-03-8392**

4. Sex **Male** 5. Color or Race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mrs. Carrie Hulén**
6. (c) Age of husband or wife if alive **52 years**
7. Birth date of deceased **9 17 1890**
(Month) (Day) (Year)

8. AGE: Years **53** Months **0** Days **5**
If less than one day hr. min.

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

10. Usual occupation **Assistant Superintendent Rolling Mill Shipping Division**

11. Industry or business **Sheffield Steel Corporation**

MOTHER FATHER
12. Name **John H. Hulén**
13. Birthplace **Mo. (State or foreign country)**
14. Maiden name **Lucy Pollard**
15. Birthplace **Mo. (State or foreign country)**

16. (a) Informant **Mrs. Carrie Hulén**

(b) Address **6040 E 14th St**

17. (a) **Burial** (b) Date thereof **9-24-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Mansfield**

18. (a) Signature of funeral director **D. H. Newcomer's Sons**

(b) Address **1401 Brush Creek Blvd**

19. (a) **9-24-43** (b) **T E Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **22nd**
1943 year. **2** hour **2** minute **P.** M.

21. I hereby certify that I attended the deceased from **Sept 2 1943** to **Sept 22 1943**
that I last saw him alive on **Sept 22 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Disease of liver - multiple myeloma, metastatic carcinoma?**
Duration **17 mo.**

Due to **Disease of liver - multiple myeloma, metastatic carcinoma?**
Due to **-----**
Other conditions (Include pregnancy within 3 months of death) **-----**

Major findings: Of operations **-----**

Of autopsy **Yes - Will be unable to get more information until histological study on male**
Underline the cause to which death should be charged statistically.

22. If of sudden or unexpected cause, state 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 **Carl R. Ferris** (M. D. or other) **MD**
Address **93 Arquette Bldg** **Sept 22, 1943**

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

Registration District No. 149 Primary Registration District No. 1002

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

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:
(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)

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?.....
If yes, name country..... (Yes or No)

3. (a) PRINT FULL NAME Ray S. Hulen

3. (b) If veteran, name war.....

3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1943 hour 12 minute 2 M.

21. I hereby certify that I attended the deceased from 1940 to 1943 that I last saw him alive on Sept 17 1943 and that death occurred on the date and hour stated above.

Immediate cause of death.....

4. Sex m 5. Color or race w

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

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

7. Birth date of deceased Sept 17 1904
(Month) (Day) (Year)

Plasmo cytoma (multiple myelomata) involving most ribs and pleura over left lung

Due to.....

Due to.....

Other conditions (Include conditions within 12 months of death).....

8. AGE: Years 53 Months 0 Days 0 If less than one day..... min.

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

Major findings:
Of operations.....

Of autopsy..... H7d

Underline the cause to which death should be charged statistically.

10. Usual occupation.....

11. Industry or business.....

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)

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?
(Specify type of place) (Means of injury)

While at work.....

23. Signature Ray S. Hulen (M. D. or other).....
Address 934 Ogden Blvd Kansas City Mo Date signed 9-17-43

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)..... (b).....
(Date received local registrar) (Registrar's signature)

SUPPLEMENTAL

