

FILED DEC 22 1943  
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:  
4210 St. John  
(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 1/2 Years

**3. (a) PRINT FULL NAME** Thomas A. Hulén  
**3. (b) If veteran,** name war No  
**3. (c) Social Security** No. None

**4. Sex** Male **5. Color or race** White  
**6. (a) Single, widowed, married, divorced** Married  
**6. (b) Name of husband or wife** Nettie  
**6. (c) Age of husband or wife if alive** 76 years  
**7. Birth date of deceased** August 20, 1867  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>76</u>	<u>3</u>	<u>17</u>	____ hr. ____ min.

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

**10. Usual occupation** Retired Farmer

**11. Industry or business** Self

**MOTHER FATHER**

**12. Name** Thomas Allen Hulén  
**13. Birthplace** Mo.  
(City, town, or county) (State or foreign country)  
**14. Maiden name** America L. Eoe  
**15. Birthplace** Ky.  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Mrs. William Turner

**(b) Address** 4210 St. John

**17. (a) Removal** Holt, Mo.  
(Burial, cremation, or removal) **(b) Date thereof** 12/10/43  
(Month) (Day) (Year)

**18. (a) Signature of funeral director** C. H. Blackman & Son, Inc.  
**(b) Address** Kansas City, Mo.

**19. (a)** 12-9-43 **(b)** H. E. Brown  
(Date received local registrar) (Registrar's signature)

**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. 4210 St. John  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Dec. day 7  
 year 1943 hour 10: minute 15 A.

**21. I hereby certify that I attended the deceased from** Dec. 5,  
1943, to Dec. 7, 1943,  
 that I last saw h. im alive on Dec. 7, 1943,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure  
 Due to Lobar Pneumonia  
 Due to Senility

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? \_\_\_\_\_

**23. Signature** Grant R. C. Hancock **(M. D. or other)** D.O.  
 Address 3900 St. John St. Date signed 12-7-43  
(Specify type of place) (a) Means of injury

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

**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 W.D. Blackman  
Licensed Embalmer No. 3639  
P. O. Address K.C. 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.**