V. S. No. 2
100M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 2 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23615

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2969

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~~:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 10 days (Specify whether
In this community 26 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 4347 Highland
(If rural, give location)

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

3. (a) PRINT FULL NAME Dr William Boone Carson Bullard

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex MALE 0

5. Color or race WHITE

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

6. (b) Name of husband or wife MRS. ANNA L. BULLARD

6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased SEPTEMBER 20 1862
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
81	9	26	hr. min.

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

10. Usual occupation RETIRED - 30 YEARS

11. Industry or business PHYSICIAN

FATHER
12. Name WILLIAM W. BULLARD
13. Birthplace UNKNOWN (City, town, or county) KENTUCKY (State or foreign country)

MOTHER
14. Maiden name ARTHEUSA ROSS
15. Birthplace UNKNOWN (City, town, or county) MISSOURI (State or foreign country)

16. (a) Informant MRS. ANNA R. BULLARD
(b) Address 4347 HIGHLAND AVENUE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 19 1944 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ MEMORIAL PARK CEMI

18. (a) Signature of funeral director D. A. Newcomer's Sons
(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 7-18-44 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16
year 1944 hour 3 minute 40 P.M.

21. I hereby certify that I attended the deceased from July 6, 1944 to July 16, 1944
that I last saw him alive on July 16, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None

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

23. Signature A. E. Upsher (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 7-17-44

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 4043

P. O. Address.....

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.