

No. 2-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 8 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2088

State File No. _____

Registration District No. 98

Primary Registration District No. 4154

Registrar's No. 66

1. PLACE OF DEATH:

(a) County Dale

(b) City or town Greenfield
(If outside city or town limits, state "RURAL" and name of township)

(c) Name of hospital or institution: Michigan Nursing Home
(If not in hospital or institution, write street number or location) 4

(d) Length of stay: In hospital or institution 30 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dale 29

(c) City or town Greenfield 1
(If outside city or town limits, write "RURAL.") 0

(d) Street No. _____ (If rural, give location)

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

3. (a) PRINT FULL NAME ALONZO TULL

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec - 8 day 31
year 1944 hour 5 minute 40/P M.

4. Sex M.O 5. Color or race W

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

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

7. Birth date of deceased No Record
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec. 23
1944 to Dec. 31 1944

that I last saw him alive on Dec. 29 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Senility
Pneumonia

8. AGE: Years 90 Months _____ Days _____ If less than one day hr. _____ min. _____

Due to _____

Due to _____

9. Birthplace No Record 9
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

11. Industry or business _____

MOTHER FATHER { 12. Name No Record

13. Birthplace No Record 9
(City, town, or county) (State or foreign country)

14. Maiden name No Record

15. Birthplace No Record 9
(City, town, or county) (State or foreign country)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Underline the cause to which death should be charged statistically.

16. (a) Informant Miss Martha Melissa

(b) Address Greenfield, Mo.

17. (a) Burial (b) Date thereof 1-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pennsylvania Cemetery

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? _____

18. (a) Signature of funeral director Sam Sencer

(b) Address Greenfield Mo

19. (a) 1-2-45 (b) Phyllis Lack
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) _____ (Specify type of place) _____

23. Signature Hershel Thompson D.O.
Address Greenfield, Mo Date signed 1-2-45

1082

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

RECEIVED
District Health Officer No. 6,
District File Number 245-127
Date Filed FEB 6 1945

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..... *Sam E. Senseney Jr*

Licensed Embalmer No. *4099*

P. O. Address. *Shenfield 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 66

Registration District No. 93 Primary Registration District No. 4154

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

1. PLACE OF DEATH:

(a) County Dade Greenfield
(b) City or town Greenfield
(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

3. (a) PRINT FULL NAME Alonzo Tull

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 w

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 90 Months _____ Days _____ (Less than one day) _____ min.

9. Birthplace _____ (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 Dec year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death uremia

Due to Chronic Nephritis
Due to Pneumonia

Other conditions (Include pregnancy within 3 months of death) 1318
Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN _____

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) _____
23. Signature Dr. Shakers _____ (M. D. or other) _____
Address Greenfield, Mo. Date signed 2-12-45

SUPPLEMENTARY

Underline the cause to which death should be charged statistically.

S-22234