

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

9671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 5 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8539**
Registrar's No. **1301**

Registration District No. 149 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:
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 2 days
(Specify whether
In this community 2 yrs
years, months or days)

3. (a) PRINT FULL NAME Mary Cullen
3. (b) If veteran, name war me
3. (c) Social Security No. no

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife Geo. E. Cullen
6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased Aug 1, 1870
(Month) (Day) (Year)

8. AGE: about 74 1/2 Years Months Days If less than one day
7 19 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Oprial

13. Birthplace no record
(City, town, or county) (State or foreign country)

14. Maiden name no record

15. Birthplace no record
(City, town, or county) (State or foreign country)

16. (a) Informant Geo. Cullen
(b) Address 1008 Paseo

17. (a) Removal (b) Date thereof Mar 21-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Revering Union

18. (a) Signature of funeral director Mrs. C. R. Foster
(b) Address 918 Broadway

19. (a) 3-21-45 (b) T. 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. 1008 Paseo
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20
year 1945 hour 6 minute 50 A.M.

21. I hereby certify that I attended the deceased from
March 18, 1945, to March 20, 1945;
that I last saw her alive on March 20, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Unknown - pending
microscopic examination

Due to
Due to

Other conditions
(Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Major findings: See above
Of operations
Of autopsy

Duration
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?

While at work? (Specify type of place)
(e) Means of injury
23. Signature Clark W. Kelly
Address Med. Dir. Gen'l Hosp. Date signed 3-20-45

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

Carlton M. ...

Licensed Embalmer No.

3414

P. O. Address

*918 Brooklyn
A.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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1301

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: Gen Hosp. #1
(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? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Mary Cullen

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex _____

5. Color or race _____

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

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

Months

Days

If less than one day

min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

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)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-21-45 (b) N. E. Brown

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26
 year 1945 hour _____ minute _____ 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 _____ Duration _____

Due to Gonorrhoea

Due to _____

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

Major findings:
 Of operations 25:2

Of autopsy _____

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature Clark W. Seely (M. D. or other) _____

Address Gen Hosp Date signed _____

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

SUPPLEMENTARY

3-8539