

S. No. 2  
 M-5-43  
 v. 5-17-39  
 > I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **9890**

FILED APR 12 1945

Registration District No. **135**

Primary Registration District No. **5579**

Registrar's No. **7**

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

9000

**1. PLACE OF DEATH:**  
 (a) County Jasper  
 (b) City or town Murphy MO  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Jasper Co. T.B. Hospital 0  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 1/2 months  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City 48  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 418 No Main  
(If rural, give location)  
 (e) Citizen of foreign country? 1 (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Claude Bullock  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month March day 17  
 year 1945 hour 10 minute 00 a M.

4. Sex M 5. Color or race Whi  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased July 21 1880  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 24 1945 to March 17 1945  
 that I last saw him alive on March 17 1945  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years Months Days If less than one day  
64 7 19 hr. min.

Immediate cause of death Pulmonary Tuberculosis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

Other conditions 13k  
(Include pregnancy within 3 months of death)

10. Usual occupation Carpenter

11. Industry or business \_\_\_\_\_

12. Name Frances Bullock

13. Birthplace New York  
(City, town, or county) (State or foreign country)

14. Maiden name Dorothy May

15. Birthplace New York  
(City, town, or county) (State or foreign country)

16. (a) Informant Records  
 (b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 3/14/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation High City Cemetery

18. (a) Signature of funeral director John J. ...  
 (b) Address High City, Mo  
 19. (a) Mar. 12, 1945 (b) Mrs. Lillie ...  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury  
 23. Signature Jose E. ... (M. D. or N. M. D.)  
 Address High City, Mo Date signed 3/12/45

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

1180

#5-3-296

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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.....

*Richard Gray Lewis*....., Registered Apprentice No. *365*  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.**