

FILED APR 4 1945

Registration District No.

3961280

Primary Registration District No.

5961

Registrar's No.

15

1. PLACE OF DEATH:

(a) County Platte See Twp.
 (b) City or town St. Paul
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Dixie Camp at Horseshoe Lake
 (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 MO (b) County Jackson
 (c) City or town 4025 Allard St. 41
 (If outside city or town limits, write "RURAL")
 (d) Street No. Kansas City MO-3
 (If rural, give location)
 (e) Citizen of foreign country? yes (Yes or No)
 If yes, name country Czechoslovakia

3. (a) PRINT FULL NAME

Charles Ullman

3. (b) If veteran,

name war no.

3. (c) Social Security

No. 490-03-5891

4. Sex Male 5. Color White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Theresa Ceretta
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan. 26 1903
 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
42	1	22	hr. <u>1</u> min.

9. Birthplace

Don't know Czechoslovakia
(City, town, or county) (State or foreign country)

10. Usual occupation

Mechanic

11. Industry or business

auto & bus

12. Name

Joseph Ullman

13. Birthplace

Don't know Czechoslovakia
(City, town, or county) (State or foreign country)

14. Maiden name

None Don't know

15. Birthplace

Don't know Czechoslovakia
(City, town, or county) (State or foreign country)

16. (a) Informant

Mrs. Theresa Ullman

(b) Address

4025 Allard St. K.C. MO.17. (a) cremated(b) Date thereof 3-18-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

St. John's Cemetery, Kansasville, MO.

18. (a) Signature of funeral director

T. J. Egan

(b) Address

Parkville MO19. (a) 3-18-45(b) Mrs. Clay Ruffee
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17
 year 1945 hour 9 min. 45 P.M.

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

Immediate cause of death	Duration
<u>Accidental Drowning</u>	

Due to _____

Due to Accidental DrowningOther 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) accident(b) Date of occurrence March(c) Where did injury occur? _____
(City or town) (County) (State)

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 Common23. Signature Tom H. Hubert (Name or other)Address Platte City MO Date signed 3-17-45

ADDITIONAL
 SUPPLEMENTARY
 INFORMATION
 REQUESTED

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged statistically.

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

RECEIVED

District Health Officer No. Platte Co. Health
District File Number 4-45-35
Date Filed 4-2-45

MAR 25 1947

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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed L. G. Francis

Licensed Embalmer No. 3451

P. O. Address Parkville 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.

Registration District No. 280

Primary Registration District No. 5961

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

1. PLACE OF DEATH:

(a) County Platte

(b) City or town Lee Sup Farley
(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 Charles Ullman

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 m

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Jan 26
(Month) (Day) (Year)

8. AGE: Years 42 Months 1 Days _____ (less than one day) min.

9. Birthplace Germany
(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) _____ (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 _____ Day _____ Year _____ Hour _____ Minute _____ M.

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

Duration

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence March 17, 1945

(c) Where did injury occur? Farley, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
House, shoe, lake
(Specify type of place)

While at work? Fishing (e) Means of injury drowned

23. Signature Tom H. Hullett Coroner
(M.D. or other)

Address Platte City, Mo Date signed 3-17-45

SUPPLEMENTARY

10450

JUN 12 1945