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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37103

FILED DEC 4 1945

Registration District No. 116 Primary Registration District No. 3020 Registrar's No. 107

37102

1. PLACE OF DEATH:

(a) County Franklin.

(b) City or town Washington.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Francis Hospital. ()
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 days. (Specify whether
In this community 3 weeks.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 31

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

(d) Street No. 640 W. 3rd St.
(If rural, give location)

(e) Citizen of foreign country? No. 0 (Yes or No)

If yes, name country X

3. (a) PRINT FULL NAME Charles N. Bullington.

3. (b) If veteran, name war X

3. (c) Social Security No. 490-14-4625

4. Sex Male ()

5. Color or race White

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

6. (b) Name of ~~XXXXXX~~ wife Levonia H. Bullington

6. (c) Age of ~~XXXXXX~~ wife if alive 59 years

7. Birth date of deceased March (Month) 27th. (Day) 1886 (Year)

8. AGE:

Years	Months	Days	If less than one day
59	7	7	hr. min.

9. Birthplace Oak Hill. (City, town, or county) Missouri. () (State or foreign country)

10. Usual occupation Trucking.

11. Industry or business X

FATHER
12. Name John L. Bullington.
13. Birthplace Unknown. (City, town, or county) Unknown. 9 (State or foreign country)

MOTHER
14. Maiden name Sarah Souders.
15. Birthplace Unknown. (City, town, or county) Unknown. 9 (State or foreign country)

16. (a) Informant Mrs. Levonia Bullington
(b) Address 640 W. 3rd St. Washington, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1945. (Month) (Day) (Year)
(c) Place: burial or cremation Washington, Mo.

18. (a) Signature of funeral director Nieburg & Vitt, Inc.
(b) Address Washington, Mo.

19. (a) 11/6/45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 4th. year 1945 hour 6:00 minute 45 A.M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw him alive on Nov 4, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Interstitial pneumonia

Due to streptococcus infection

Due to Chr. asthma

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature [signature] (M. D. or other) M.D.

Address [signature] Date signed 11/5/45

1449

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 12-3-45

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 me

Registered Apprentice No.

working under my personal supervision.

Signed A. F. Nickerson

Licensed Embalmer No. 2387

P. O. Address Washington, Me

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.