

S. No. 2
M-8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26989

State File No. _____

FILED AUG 10 1946

Registration District No. 144

Primary Registration District No. 4234

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Iron

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

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

(d) Length of stay: In hospital or institution 1 year
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5656 Waterman
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Kate May Bull

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 10
year 1946 hour 6:20 minute A M.

21. I hereby certify that I attended the deceased from July 45 1945 to August 10 1946
that I last saw her alive on August 10 1946
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white

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

6. (b) Name of husband or wife James M. Bull

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

7. Birth date of deceased Nov. 14 1863
(Month) (Day) (Year)

Immediate cause of death Amyotrophic Lateral Sclerosis Duration 3 yrs.

Due to _____

Due to _____

Other conditions Arterial sclerosis 10 yrs.
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

82	8	26	hr. min.
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Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER

12. Name Ben May

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

14. Maiden name Demetria A. Simmons

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

16. (a) Informant Dr. Ben M. Bull

(b) Address Ironton Missouri

17. (a) burial (Burial, cremation, or removal)

(b) Date thereof 8-12-46
(Month) (Day) (Year)

(c) Place: burial or cremation St. Louis Missouri

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 0

18. (a) Signature of funeral director Norman White & Sons

(b) Address 215 White Ironton Missouri

19. (a) 8-15-46 (Date received local registrar)

(b) McAris Jones (Registrar's signature)

23. Signature Ben M. Bull (M. D. or other) M.D.

Address Ironton, Mo Date signed 8-10-46

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

7
1
0

25831

128

RECEIVED

District Health Officer No. 4

District File Number 946-2592

Date Filed 9-9-46

SEP 12 1946

SEP 10 1946

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 Paul J. White

Licensed Embalmer No. 3012

P. O. Address Clinton 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.