

Registration District No. **107**

Primary Registration District No. **3019**

1. PLACE OF DEATH:

(a) County **Bunklin**
(b) City or town **Kennett Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
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 **Mo** (b) County **Bunklin**
(c) City or town **Kennett**
(If outside city or town limits, write "RURAL")
(d) Street No. **923 S Jackson**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **JAMES F FRANKLIN MCCULLY**

(b) If veteran, name war **No** (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **1**
6. (b) Name of husband or wife **Betty McCreedy** 6. (c) Age of husband or wife if alive **73** years
7. Birth date of deceased **Dec 10 1876**
(Month) (Day) (Year)

8. AGE: Years **71** Months **9** Days **21** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Retired Turner**

11. Industry or business **Retired**

MOTHER FATHER
12. Name **John McCully**
13. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)
14. Maiden name **Catherine Herbs**
15. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)

16. (a) Informant **Evert McCreedy**
(b) Address **Kennett Mo.**
17. (a) **Burial** (b) Date thereof: **10-2-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Ridge**

18. (a) Signature of funeral director **W.T. E. ...**
(b) Address **Jennett Mo.**
19. (a) **10-2-1947** (b) **Earl ...**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **1**
year **1947** hour **1** minute **A.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 **Coronary occlusion, 1 day**
Due to _____
Due to _____

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

Major findings: _____
Of operations **g. H.**
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 **3**
23. Signature **Walter G. ...** (M.D. or other) **Cor**
Address **Kennett Mo** Date signed **10-1-47**

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

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

15
2
2

RECEIVED

District Health Office No. 2,

District File Number 1067-1295

Date Filed 10-6-47

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.....

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.