

No. 2
12-45
17-39
X47070

FILED NOV 17 1947

Registration District No. **1000**

Primary Registration District No. **1000**

Registrar's No. **1338**

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

1. PLACE OF DEATH:

(a) County Bassett

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

(c) Name of hospital or institution:
State Hospital No 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 - MO 14 days
(Specify whether years, months or days)

In this community 2 mos. 14 days

3. (a) PRINT FULL NAME Della F Gullett

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex F 5. Color or race H

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

6. (b) Name of husband or wife H. E. Gullett

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

7. Birth date of deceased: July 6 1884
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>63</u>	<u>4</u>	<u>4</u>	hr. min.

9. Birthplace: MO (City, town, or county) 0 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At home

12. Name Jo Ann McCray

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

14. Maiden name Etta Turnage

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

16. (a) Informant Revised Hospital

(b) Address St Joseph Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/10/47
(Month) (Day) (Year)

(c) Place: burial or cremation Richmond, Missouri

18. (a) Signature of funeral director Heaton - Bowman

(b) Address St. Joseph, Mo.

19. (a) 11-12-47 (Date received local registrar) (b) M. L. Jenkins (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Ray

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

(d) Street No. Not given
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 10
year 1947 hour 3-30 minute P M.

21. I hereby certify that I attended the deceased from Aug 26, 1947, to NOV 10, 1947.
that I last saw him alive on Nov 10, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia

Due to arteriosclerosis

Due to

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature C. E. Salyer (M. D. certifying)
Address St Joseph Mo Date signed 11-10-47

NOV 24 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.....

Francis Joseph Wyford Jr.

Registered Apprentice No. *444*

working under my personal supervision.

Signed *Frank A. Berman*

Licensed Embalmer No. *1710*

P. O. Address *St. Joseph, Pa.*

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.