

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 15 1948
386

State File No.

Registration District No. 386

Primary Registration District No. 6203

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Rural Current top
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas

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

(d) Street No. _____
(If rural, give location)

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

3. (a) PRINT FULL NAME Kate E Hull

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 13
year 1948 hour 11 minute A M.

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

4. Sex F 5. Color or face W 6. (a) Single, widowed, married Married
divorced _____

6. (b) Name of husband or wife George Hull 6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased Feb 7 1869
(Month) (Day) (Year)

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? _____

8. AGE: Years 79 Months 9 Days 6 If less than one day _____ hr _____ min.

Immediate cause of death apoplexy

Due to _____

Due to _____

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

10. Usual occupation Housewife

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

Major findings: Of operations _____

Of autopsy _____

MOTHER FATHER

11. Industry or business _____

12. Name John Ray

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

14. Maiden name Moore

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

23. Signature L. Lee Randall M. D. or other _____
Address Licking Miss Date signed _____

16. (a) Informant Raymond Hull

(b) Address Archer Creek

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-48
(Month) (Day) (Year)

(c) Place: burial or cremation Ashley Creek Cem

18. (a) Signature of funeral director Wm. J. Ferguson

(b) Address Licking Miss

19. (a) Dec 2-1948 (Date received local registrar) (b) Wm. C. E. Murphy (Registrar's signature)

While at work _____ (Specify type of place) (c) Means of injury _____

23. Signature L. Lee Randall M. D. or other _____
Address Licking Date signed _____

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

RECEIVED 12-9-48
Director Health Officer No. 5,
124876
12-9-48
Date Filed

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.....

Not Embalmed
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Carbur E Ferguson.*

Licensed Embalmer No. *3445*

P. O. Address *Licking, 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.