

FILED SEP 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30949

No. 300
10-48

BIRTH NO. _____		REG. DIST. NO. <u>176</u>	PRIMARY REG. DIST. NO. <u>5-6326</u>	Registrar's No. <u>22</u>
1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Lawrence</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Holtown</u>		c. LENGTH OF STAY (in this place) <u>none</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Holtown</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>at home</u>		d. STREET ADDRESS (If rural, give location) <u>Osage Trp</u>		
3. NAME OF DECEASED (Type or Print) <u>Timmie Lee Bullard</u>		a. (First) <u>Timmie</u>	b. (Middle) <u>Lee</u>	c. (Last) <u>Bullard</u>
4. DATE OF DEATH (Month) (Day) (Year) <u>9-5-1950</u>	5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8-24-1928</u>
9. AGE (In years last birthday) <u>22</u>	IF UNDER 1 YEAR Months <u>0</u>	IF UNDER 1 YEAR Days <u>12</u>	IF UNDER 24 HRS. Hours <u>0</u>	IF UNDER 24 HRS. Min. <u>12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student SMS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lawrence Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Lawrence Co.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Harold Bullard</u>		
13b. MOTHER'S MAIDEN NAME <u>Faye Rogers</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Arlene Bullard</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY (If yes, give war or dates of service) <u>World War II</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Harold Bullard</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Shot self in head</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last.		DUE TO (b) <u>with 22 Target</u>		<u>3 min</u>
DUE TO (c) <u>Revolver - white target</u>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Practicing</u>		<u>5:11</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <u>In lot near home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Lawrence Mo</u>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>9/5/50 3:30 AM</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Gun shot wound in head</u>		
22. I hereby certify that I attended the deceased from <u>after death</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>9-5-50</u> , 19 <u>50</u> , and that death occurred at <u>3:30 AM</u> m., from the causes and on the date stated above.				
23a. SIGNATURE <u>Herman Surridge</u>		23b. ADDRESS <u>Marionville Mo</u>		23c. DATE SIGNED <u>9/8/50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		24b. DATE <u>9-8-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Holtown</u>	24d. LOCATION (City, town, or county) (State) <u>S of Holtown Mo</u>
DATE REC'D BY LOCAL REG. <u>9-16-50</u>	REGISTRAR'S SIGNATURE <u>W.S. Burgess</u>	158	25. FUNERAL DIRECTOR'S SIGNATURE <u>H.R. Simon</u>	ADDRESS <u>Miller Mo</u>

(Licensed Embalmer's Statement on Reverse Side)

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

550
1

OCT 24 1950

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED SEP 19 1950

Dist. File 450-1657

Date Filed 9-23-50

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed E. R. Leiman

Licensed Embalmer No. 3297

P. O. Address Miller 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.