No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 19 1953

State File No. 30787

BIRTH NO. _____ REG. DIST. NO. 391 PRIMARY REG. DIST. NO. 6153 Registrar's No. 36

1. PLACE OF DEATH
a. COUNTY: Stoddard
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bell City RI
c. LENGTH OF STAY (in this place): 30 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Stoddard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bell City RI Rural 1030 0
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): Jonathan
c. (Last): Bullard

4. DATE OF DEATH (Month) (Day) (Year): July 30 1953

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 14, 1862
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months 3, Days 16 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Olney Ill. 1
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Jonathan Bullard
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Deceased.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: C.E.Bullard. Bell City.MO.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Endocaitis — INTERVAL BETWEEN ONSET AND DEATH: —

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Vascular Hypertension — —
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 444x
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/27, 1953, *to* 7/30, 1953, *that I last saw the deceased alive on* 7/27, 1953, *and that death occurred at* — *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J A Cline MD
23b. ADDRESS: Oran Mo
23c. DATE SIGNED: 8/1/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/1, 1953
24c. NAME OF CEMETERY OR CREMATORY: Hagey Cemetery
24d. LOCATION (City, town, or county) (State): Stoddard .CO. MO.

DATE REC'D BY LOCAL REG.: Aug. 10, 1953
REGISTRAR'S SIGNATURE: Bernice Moore 360
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Watkins Funeral Service Bloomfield. MO.

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Signed Walter Marsh Watkins

Signed _____
Student Embalmer

Licensed Embalmer No. 717

P. O. Address Dexter, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.