

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 127

No. 300
10.48
1082
4

FILED JAN 19 1954

BIRTH NO. _____ REG. DIST. NO. 30 PRIMARY REG. DIST. NO. 4838 Registrar's No. 4

1. PLACE OF DEATH a. COUNTY <u>Benton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>	
b. CITY OR TOWN <u>Warsaw</u>	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) <u>Versailles</u> <u>0710</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lake side Rest Home</u>		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <u>THOMAS</u> b. (Middle) <u>NONE</u> c. (Last) <u>BULL</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 14, 1954</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>Oct 2, 1860</u>	9. AGE (In years last birthday) <u>93</u>	If UNDER 1 YEAR Months <u>3</u> Days <u>12</u>	If UNDER 24 HRS. Hours <u></u> Mins. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			

13a. FATHER'S NAME <u>Thomas H. Bull</u>	13b. MOTHER'S MAIDEN NAME <u>Katherine C. McDonald</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Charley Bull</u>	ADDRESS <u>Sallisbury Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Senility</u>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senility</u> DUE TO (b) _____ DUE TO (c) _____ *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. II. OTHER SIGNIFICANT CONDITIONS <u>Severe intestinal hemorrhage etiology unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unk -</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>578X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 18 Aug, 1953, to 14 Jan, 1954, that I last saw the deceased alive on 14 Jan, 1954, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ward A. Glenn M.D.</u>	23b. ADDRESS <u>Warsaw Mo</u>	23c. DATE SIGNED <u>16 Jan 54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan 16, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Morgan Co Mo</u>
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DATE REC'D BY LOCAL REG. <u>Jan 16 1954</u>	REGISTRAR'S SIGNATURE <u>Jas. A. Logan</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Reed</u>	ADDRESS <u>Warsaw</u>
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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.

Student
Student Embalmer

Signed _____

John J. Teaser

Licensed Embalmer No. 4098

P. O. Address Warsaw

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.