

FILED JUL 9 1954

STANDARD CERTIFICATE OF DEATH

State File No. **19746**

BIRTH NO. _____ REG. DIST. NO. **239** PRIMARY REG. DIST. NO. **5825** Registrar's No. **16**

1. PLACE OF DEATH a. COUNTY New Madrid		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, write RURAL and give township) Parma rural		c. LENGTH OF STAY (In this place) 41 yrs	c. CITY OR TOWN Parma d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) 0720	

3. NAME OF DECEASED (Type or Print)	a. (First) Katie	b. (Middle)	c. (Last) Bultmann	4. DATE OF DEATH (Month) (Day) (Year) June 9 1954
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Mar. 8, 1874	9. AGE (In years last birthday) Months 80	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	11. BIRTHPLACE (City and State or Foreign Country) / State of Illinois	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Henry Tammem	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Ferdinand Bultmann
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME Virgil Wagner Parma Mo;	ADDRESS
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		MEDICAL CERTIFICATION 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) 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 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **June 7, 1954**, to **June 9, 1954**, that I last saw the deceased alive on **June 9, 1954**, and that death occurred at **5:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. Geo. W. Hunt MD.	23b. ADDRESS Parma Mo.	23c. DATE SIGNED 6/10/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE June 11, 1954	24c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery, near Carrollton Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. 6/10/54	REGISTRAR'S SIGNATURE Dr. Geo. W. Hunt MD.	25. FUNERAL DIRECTOR'S SIGNATURE William J. Smith	ADDRESS Parma Mo;
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

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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.....
Signature of Student Embalmer

Signed *Walter Marsh Watkins*

Licensed Embalmer No. *4717*

P. O. Address *Dexter, M*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.