

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027961

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 137

FILED JUL 24 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Saline</b>		a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		c. CITY OR TOWN <b>Independence</b>	
Length of stay in 1b <b>35 yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Marshall State School &amp; Hosp., Marshall, Mo.</b>		d. STREET ADDRESS (If outside, give location) <b>1421 W. Walnut St.</b>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Max Frederick Bullard</b>			4. DATE OF DEATH Month Day Year <b>7-21-1961</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-15-1909</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patient</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <b>51 yrs.</b> Months Days Hours Min.
11. BIRTHPLACE (City and state, or country) <b>Independence, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Charles Walter Bullard</b>		13b. MOTHER'S MAIDEN NAME <b>Ruth Johnson</b>	14. NAME OF HUSBAND OR WIFE <b>---</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT <b>Records of Marshall State School &amp; Hosp., Marshall, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Palsy, Spastic type</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Several weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic, wheel-chair invalid requiring infantile care</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>4-1-1959</b> to <b>7-21-1961</b> and last saw her alive on <b>7-20-1961</b>		Death occurred at <b>2:50 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>A. B. Day, M.D.</b>		22b. ADDRESS <b>Marshall State School &amp; Hosp., Marshall, Mo.</b>	22c. DATE SIGNED <b>7-21-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7-21-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mound Grove cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Independence, Mo.</b>
24. FUNERAL DIRECTOR <b>Campbell-Lewis, Marshall, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>7-21-'61</b>	26. REGISTRAR'S SIGNATURE <b>Carl G. Reed</b>

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 R. W. Campbell Jr.

Licensed Embalmer No. 3469

P. O. Address Marshall, W. Va.

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.