

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-047009

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 868

FILED DEC 20 1963

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Boone</b>  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b> Length of stay in 1b <b>55 days</b>  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Ellis Fischel State Cancer</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Audrain</b>  c. CITY OR TOWN <b>Mexico</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <b>111 N. Alabama</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Merrill</b> Middle <b>Edwin</b> Last <b>Bulson, Sr.</b>			<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>17</b> Year <b>1963</b>					
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 15, 195</b>	<b>9. AGE (last birthday)</b> <b>68</b>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HR</b> Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Ret. Labor er &amp; Hotel Clerk</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>none</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Enid, Oklahoma</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>	
<b>13a. FATHER'S NAME</b> <b>I. F. Bulson</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Stanley</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>Joe Eddie Bulson</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Unknown</b>			<b>16. SOCIAL SECURITY NO.</b>			<b>17. INFORMANT</b> Address <b>Hospital Records, Columbia, Missouri</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkins disease</b> DUE TO (b) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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>Broncho pneumonia</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 INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>								
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE		
<b>21. I attended the deceased from</b> <b>10-30-63</b> <b>12-17-63</b> and last saw him alive on <b>12-17-63</b> Death occurred at <b>3:30</b> P on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Degree or title) <i>Paul Inerick Jr. M.D.</i>				<b>22b. ADDRESS</b> <b>E.F. State Cancer Hospital</b>		<b>22c. DATE SIGNED</b> <b>12-17-63</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE</b> <b>12/20/63</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ELMWOOD CEM</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>MEXICO, MO</b>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>PRECHT FUNERAL Home MEXICO, MO</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>Dec 17, 1963</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Wm R E Palmer</i>			

DO NOT WRITE ON THIS STUB  
 AMENDED  
 VS 300 Rev. 4/59  
 1 0109  
 2 0047  
 3  
 4 0  
 5 1  
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 9 201X  
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 12 3-0  
 13 3-0  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 SHOULD READ  
 ITEM NO.  
 BY AFFIDAVIT OF  
 MEDICAL CERTIFICATION  
 DOCUMENT  
 USE BLACK INK OR TYPEWRITER RIBBON

DEC 24 1963

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 Albert A. Eaker

Licensed Embalmer No. 5231

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