MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

14389
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan — Registration District No. 85
(b) Township or — Primary Registration District No. 1001 — Registered No. 480
(c) City St. Joseph Mo — (d) Street No. State Hospital #2. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 7 yrs. 3 mos. 26 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Julia Gulick
(a) Residence, No. State Hospital # 2 St. — Jackson Co. Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F — 4. COLOR OR RACE W. — 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Marr.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Selmon Gulick

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown

7. AGE — YEARS Est. 48 — MONTHS ? — DAYS ? — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Cincinnati, Ohio (STATE OR COUNTRY) Ohio

FATHER
13. NAME Chas. Bower
14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Germany

MOTHER
15. MAIDEN NAME Josepline Butler
16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Ireland

17. INFORMANT State Hosp. records (ADDRESS) St. Joseph, Missouri.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Olivet DATE 4/30/40

19. FUNERAL DIRECTOR (NAME) H. O. Sidenfadey & Son (ADDRESS) 1802 Union Ave. St. Joseph Mo

20. FILED Apr 30, 1940 — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-26, 1940

22. I HEREBY CERTIFY, That I attended deceased from 7-15, 1939, to 4-26, 1940
I last saw her alive on 4-26, 1940. Death is said to have occurred on the date stated above, at 9:45 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinomatosis of pelvic organs	?

Other contributory causes of importance:

Name of operation None Date of
What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Sam Nelson M. D.
(Address) State Hospital No. 2, St. Joseph, Mo

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14389

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 480

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Julia Gulick
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Mar
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 48 Months Days If less than one day min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 26 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from 19, to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.
Immediate cause of death Carcinoma Pelvic Organs Duration
Due to Origin unknown
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work in (Specify type of place) (e) Means of injury
23. Signature Sam Nelken (M. D. or other)
Address State Hosp # 2 Date signed

SUPPLEMENTARY

53

S-14389