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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27720
Registrar's No. 8354

Registration District No. 399

Primary Registration District No. 1002

I. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Eastside Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 8 years _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4911 East 27 Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

8. (a) PRINT FULL NAME Mr. Arthur Warren Bullard

8. (b) If veteran, name war World War 3. (c) Social Security No. 067-01-7205

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mrs. Mary D. Bullard 6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased December 7, 1889
(Month) (Day) (Year)

8. AGE: Years 50 Months 8 Days 18 If less than one day _____ hr. _____ min.

9. Birthplace North Platte Nebraska
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Alexander Hamilton Corr. School

MOTHER FATHER

12. Name Frank Bullard
13. Birthplace Unk. own Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unk. Davis
15. Birthplace Unknown
(City, town or county) (State or foreign country)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25 year 1940 hour 10 minute 35 P.M.

21. I hereby certify that I attended the deceased from April 29 to Aug 25 1940 that I last saw him alive on Aug 25 1940 and that death occurred on the date and hour stated above.

Immediate cause of death arterio chronic enceph. also Malaria, involving the left cerebrum in the Rolandic area & in the Pons. Acute focal tumor on L side, non malignant coronary occlusion with organized infarct in the left ventricle. Duration _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

9/25
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? _____ (Specify type of place) (e) Means of injury _____

23. Signature John C. Caranagh (M. D. or other) _____
Address H 9th E-27 R.E. No Date signed _____

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

Li 4500

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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address W. C. 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27720

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 3354

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(c) Name of hospital or institution: Eastside Hospital
(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 Arthur Warren Bullard

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

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 Months Days If less than one day hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (b) Date thereof..... (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 8/27/40 (b) M. M. Crow (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Aug day 25 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19..... and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings of operations.....

adenoc. non malignant

Of autopsy.....

Duration
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?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTAL COPY

S-27720