No. 2
13-40

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2242

Registration District No. 108 Primary Registration District No. 3411 Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Excelsior Springs, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Months 26 Days (Specify whether years, months or days)
In this community 4 Months 26 days

2. USUAL RESIDENCE OF DEACEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No.: 2741 Gillham Road
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: James E. Cullen
3. (b) If veteran, name war: World War
3. (c) Social Security No. 714-05-7426
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Florence L. Cullen
6. (c) Age of husband or wife if alive: 44 years
7. Birth date of deceased: May (Month) 1 (Day) 1889 (Year)

8. AGE: Years	Months	Days	If less than one day
51	7	28	hr. ____ min.

9. Birthplace: Eutaw (City, town, or county) Alabama (State or foreign country)
10. Usual occupation: Railway Express Chauffeur
11. Industry or business: Railway Express
MOTHER FATHER
12. Name: John I. Cullen
13. Birthplace: Ireland (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Elizabeth Collins
15. Birthplace: No Record (City, town, or county) (State or foreign country)
16. (a) Informant: Hospital Records, Veterans Adm.
(b) Address: Excelsior Springs, Missouri
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-29-1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Kansas City, Missouri
18. (a) Signature of funeral director: Claud Prichard
(b) Address: Excelsior Springs, Mo.
19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day 29th. year 1940 hour 2 minute 45 A. M.
21. I hereby certify that I attended the deceased from August 3rd. 1940, to December 29 1940 that I last saw him alive on December 29th. 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature ____ (M. D. or other)
Address ____ Date signed

(Licensed Embalmer's Statement on Reverse Side)

This is a copy of death Certificate
Mrs Teeter gave me but it does not
comply with the rules which the
Railroad Retirement Board have
Mrs Teeter

200 N

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 comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
4-25-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2242

Registration District No. 198 Primary Registration District No. 3011 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Vets adm Fac (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town K C. Mo (If outside city or town limits, write "RURAL")

(d) Street No. 2741 Gillham Rd (If rural, give location)

(e) Citizen of foreign country ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME James E Cullen

3. (b) If veteran, name war Worldwar

3. (c) Social Security No. .....

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Florence L.

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased May (Month) 1 (Day) 1884 (Year)

8. AGE: Years 51 Months 7 Days 28 If less than one day ..... hr. ..... min.

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

10. Usual occupation R.W. Express Chauffeur

11. Industry or business Railway Express

FATHER
12. Name John J Cullen
13. Birthplace Ireland (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Collins
15. Birthplace Mk. (City, town, or county) (State or foreign country)

16. (a) Informant Hosp. Records

(b) Address Excelsior Spgs Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-29-1940 (Month) (Day) (Year)

(c) Place: burial or cremation K.C. Mo.

18. (a) Signature of funeral director Claud Prichard

(b) Address Excelsior Spgs Mo

19. (a) 6/23/41 (Date received local registrar) (b) Mrs Ria McCracken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29 year 1940 hour 2:45 minute A M.

21. I hereby certify that I attended the deceased from Aug 3, 1940, to Dec 29, 1940, that I last saw him alive on Dec 29, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Insufficiency and Myocardial fibrosis

Due to Aortic insufficiency And Severe Aortisis

Due to Arteriosclerosis

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

Major findings: Of operations No Operation

Of autopsy Cardiac Enlargement Myocardial Fibrosis + Severe Aortitis

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature Buell L. Ashmore (M. D. or other) MD

Address Excelsior Springs Mo Date signed 12/29/40

SUPPLEMENTARY