

FILED APR 17 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 4124

1. PLACE OF DEATH

(a) County Clark  
(b) City or town Kahaha  
(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 \_\_\_\_\_ (Specify whether)  
In this community 3 yrs. years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Clark  
(c) City or town Kahaha 23  
(If outside city or town limits, write "RURAL") 1  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Bert Bull

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Ida 6. (c) Age of husband or wife if alive 70 years  
7. Birth date of deceased Sept. 9 - 1871  
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation retired Merchant

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Dr. T. A. Bull  
13. Birthplace Ill. (City, town, or county) (State or foreign country)  
14. Maiden name Sarah Bassett  
15. Birthplace Ill. (City, town, or county) (State or foreign country)

16. (a) Informant Ida S. Bull

(b) Address Kahaha Mo.

17. (a) Burial (b) Date thereof Feb. 19-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kahaha li.

18. (a) Signature of funeral director Gettys Wied

(b) Address Kahaha Mo.

19. (a) 2-24-46 (b) Perry J. Boston  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16  
year 1945 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from FEB 16  
to Feb 16 1945 to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on Feb 16 - \_\_\_\_\_ 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration \_\_\_\_\_

Due to Coronary Arteriosclerosis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations None  
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 \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Kahaha Mo Date signed \_\_\_\_\_

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

RECEIVED

District Health Officer No. 10

District File Number 4-45-633

Date Filed APR 13 1945

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 *Alis L. Lutting*

Licensed Embalmer No. *2965*

P. O. Address *Lurray 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, fact should be so stated above.