

FILED NOV 6 1945

State File No.

Registration District No. 244

Primary Registration District No. 0834

Registrar's No. 11

1. PLACE OF DEATH:
 (a) County Newton
 (b) City or town rural - Newton Twnshp
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Neosho Route 5
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 1/2 months
(Specify whether years, months or days)
 In this community 2 1/2 months

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Newton
 (c) City or town rural
(If outside city or town limits, write "RURAL")
 (d) Street No. Neosho route 5
(If rural, give location)
 (e) Citizen of foreign country? no
(Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Terence John Tully, jr.
 3. (b) If veteran, name war none
 3. (c) Social Security No. none

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month October day 18
 year 1945 hour 3:50 minute P M.

4. Sex male 5. Color or race white
 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive 9 years
 7. Birth date of deceased October 1941
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 18 1945 to Oct 18 1945
 that I last saw him alive on Oct 18 1945
 and that death occurred on the date and hour stated above.

8. AGE: Years 4 Months 0 Days 9
 If less than one day
 hr. min.

Immediate cause of death asphyxiation
 Duration

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

Due to drowning - accidental
 Due to.....

10. Usual occupation at home

Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations
 Of autopsy

11. Industry or business.....
 12. Name Brig Gen. Terence J. Tully, sr
 13. Birthplace Point Comfort, Va.
(City, town, or county) (State or foreign country)
 14. Maiden name Margaret Gunter
 15. Birthplace Salt Lake City Utah
(City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
183.3
19

16. (a) Informant T. J. Tully, sr.
 (b) Address Route 5, Neosho, Mo.
burial
 17. (a) (Burial, cremation, or removal) (b) Date thereof Oct 20, 1945
(Month) (Day) (Year)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) accident
 (b) Date of occurrence October 18, 1945
 (c) Where did injury occur? in stream near home
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
near farm home

(c) Place: burial or cremation Park Cemetery
 18. (a) Signature of funeral director Knell Mortuary
 (b) Address Carthage, Mo.
 19. (a) Oct. 20-45 (b) Miss Allie Parnell
(Date received local registrar) (Registrar's signature)

While at work? play (Specify type of place)
 (c) Means of injury drowning
 23. Signature Capt Paul T. Hohmann, M.D.
 Address Camp Crowder, Mo. Date signed 10/18/45

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

157D

NOV 17 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.

RECEIVED NOV 2 1945

Signed *Lucy Kneel-Bucknell*

Licensed Embalmer No. *2510*

P. O. Address. *Carthage, Mo.*

District Health Officer No.

District File Number *NOV 2 1945*

Date Filed *NOV 2 1945*

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.

34273

Registration District No. 244

Primary Registration District No. 5834

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

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Rural Marion Twp.
(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 _____ 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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Terence J. July Jr.
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 9 (Month) (Day) (Year)

8. AGE: Years 4 Months 0 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) (Mrs. Allie Parnell)
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ after 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 _____
Of autopsy _____

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 _____

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



