

S. No. 2  
M-5-43  
y. 5-17-39  
P 1 X36871

FILED NOV 25 1946

State File No. \_\_\_\_\_

Registration District No. 197

Primary Registration District No. 1002

Registrar's No. 1003

1. 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: St Marys Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 Days  
(Specify whether years, months or days)

In this community unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 41

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 2820 Baltimore  
(If rural, give location)

(e) Citizen of foreign country? unknown (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME George Bullock BULLOCK

3. (b) If veteran, name war no (c) Social Security No. Do not know

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 \_\_\_\_\_ years

7. Birth date of deceased 1895  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 9 year 1946 hour 6 minute 30 P. M.

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

8. AGE: Years Months Days If less than one day

51 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death \_\_\_\_\_  
Primary carcinoma of lung \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Do not know \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation Electrician opr.

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

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

MOTHER FATHER { 12. Name Do not know \_\_\_\_\_ 9

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

14. Maiden name Immer \_\_\_\_\_ 7

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy See Above

16. (a) Informant St Marys Hospital

(b) Address 12 C Mo

17. (a) Buried (b) Date thereof Nov 13-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Cabrini 12 C Mo

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? \_\_\_\_\_

18. (a) Signature of funeral director Parsons

(b) Address 12 C Mo

19. (a) 11-12-46 (b) Steraldine Holmes  
(Date received local registrar) (Registrar's signature)

While at work \_\_\_\_\_  
(Specify type of work)

23. Signature A. E. Cooper M.D.  
Address 2800 Main Date 11/14/46  
(M. D. or other)

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

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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..... *Francis Walter* .....

Licensed Embalmer No. *2744* .....

P. O. Address.....

**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.**