

S. No. 2
DM-5-43
v. 5-17-39
I X36671

FILED **MAY 19 1947**

Registration District No. **42** Primary Registration District No. **1000**

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

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 days (Specify whether
 In this community 5 days years, months or days)

3. (a) PRINT FULL NAME MARY STULL
3. (b) If veteran, name war None **3. (c) Social Security No.** None

4. Sex Female **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 July 19, 1894
(Month) (Day) (Year)

8. AGE: Years 52 Months 9 Days 15 If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business None

MOTHER FATHER
12. Name Alec Stull
13. Birthplace Wisconsin
14. Maiden name Susanna Swinney
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Charles Young (niece)

(b) Address 2904 Lafayette St., St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 5/16/47
(Month) (Day) (Year)

(c) Place: burial or cremation Grant City, Missouri

18. (a) Signature of funeral director Prugh & Dunfee

(b) Address Grant City, Missouri

19. (a) Date received local registrar May 16, 1947 **(b) Registrar's signature** E.C. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County FuWorthn // 3
 (c) City or town Grant City (rural) 0
(If outside city or town limits, write "RURAL")
 (d) Street No. R. P. D. # 1 0
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4, year 1947 hour 6 minute 55 A. M.

21. I hereby certify that I attended the deceased from April 30 to May 3, 1947, that I last saw her alive on May 13, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of rectum (see 2)
Carcinoma of prostate - Present

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)
Major findings: James H. P.
Of operations: _____

Of autopsy _____

Duration 62m

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)** _____
Means of injury _____

23. Signature Frank W. Nardigan (M. D. or other) _____

Address 620 Duquesne **Date signed** 5/16/47

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, ~~only~~.....

.....
working under my personal supervision.

Signed.....

Registered Apprentice No.....

Licensed Embalmer No. *3986*.....

P. O. Address *St Joseph, 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.