

1. PLACE OF DEATH

(a) County Cole
(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 821 - Jefferson St. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay In hospital or institution _____ (Specify whether)
In this community 53 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole 26
(c) City or town Jefferson City 5
(If outside city or town limits, write "RURAL")
(d) Street No. 1506-Vista 4
(If rural, give location) 1/2
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Albert J. Dulle

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 Helen 6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased Sept 13 1894
(Month) (Day) (Year)

8. AGE: Years 53 Months 0 Days 2 If less than one day
hr. _____ min. _____

9. Birthplace Jefferson City Mo. 6
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business Quality Beverage Co.

MOTHER FATHER
12. Name Bernard H. Dulle
13. Birthplace Prussia Germany
(City, town, or county) (State or foreign country)
14. Maiden name Mrs. Mary Baker
15. Birthplace Kalmar Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Helen Dulle

(b) Address 506-Vista

17. (a) Burial (b) Date thereof 9-18-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Resurrection

18. (a) Signature of funeral director Jennie Devine

(b) Address 707 Jefferson

19. (a) 9-17-47 (b) R. P. Devine MD
(Date received local registrar) (Registrator's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 15
year 1947 hour 10 minute 05 A.M.

21. I hereby certify that I attended the deceased from Dead when viewed 19____
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Sudden

Due to Had been treated for
Due to Angina pectoris & coronary block

Other conditions (Include pregnancy within 3 months of death)

Major findings: 94A
Of operations _____
Of autopsy _____

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? 5

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature J. Leslie MD (M. D. or other)
Address Jefferson City Mo. Date signed 9-17-47

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

6
5
4

DATE FILED 9-29-47
DISTRICT FILE NUMBER
HEALTH OFFICER NO. 9

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 J. Anderson

Licensed Embalmer No. 3641

P. O. Address June

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.