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FILED AUG 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23694

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3086

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give townships) Kansas City	c. LENGTH OF STAY (in this place) 30 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3321 Woodland		d. STREET ADDRESS (If rural, give location) 3321 Woodland	

3. NAME OF DECEASED (Type or Print) Lester M. Tull			4. DATE OF DEATH (Month) (Day) (Year) 7/10/49		
a. (First)	b. (Middle)	c. (Last)	a. (Month)	b. (Day)	c. (Year)

5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH 6/24/1900	9. AGE (in years last birthday) 49	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Blue Mound, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
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13a. FATHER'S NAME Wm. F. Tull		13b. MOTHER'S MAIDEN NAME Hattie Skivers		14. NAME OF HUSBAND OR WIFE Unknown	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY 496-09-5947	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. John G. Vogel, Jackson County			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound			INTERVAL BETWEEN ONSET AND DEATH	
	ANTECEDENT CAUSES DUE TO (b) <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>				
	DUE TO (c)				
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			E9712	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION No. Relative to Sign Post Permit			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) suicide	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Kansas City Jackson Mo			
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21d. TIME OF INJURY 7-10-49 8:30 p.m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Self-inflicted gunshot wound			
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22. I hereby certify that I attended the deceased from _____, 19____, and that death occurred at **2:30 P.m.**, 19____, from the causes and on the date stated above.

23. SIGNATURE Hugh H. Owens Coroner (Degree or title)		23b. ADDRESS 1034 Reade Bldg		23c. DATE SIGNED 7-12-49	
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24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 7/13/49	24c. NAME OF CEMETERY OR CREMATORY Glenwild	24d. LOCATION (City, town, or county) (State) Westline Mo.		
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DATE REC'D BY LOCAL REG. 7-15-49	REGISTRAR'S SIGNATURE Seraldine Palmer	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. W. Wigerman & Sons, K.C. Mo.			
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

J. S. Walters

Signed _____
Student Embalmer

Licensed Embalmer No. *2744*

P. O. Address *K. C. 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.