# URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAR 17 1960

60-012401

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2621 STATE FILE NUMBER

MENDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS — Length of stay in 1b 1 DAY

c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. ANTHONY'S HOSPITAL — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 6227 WYOMING — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First FLORENCE Middle (N.M.I.) Last BULLOCK

4. DATE OF DEATH Month MARCH Day 5, Year 1960

5. SEX FEMALE

6. COLOR OR RACE CAUCASIAN

7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ X

8. DATE OF BIRTH 2/12/1878

9. AGE (last birthday) 82 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY AT HOME

11. BIRTHPLACE (City and state or country) HAYDEN, MISSOURI

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME ROBERT NELSON'

13b. MOTHER'S MAIDEN NAME 1st UNKNOWN SNEED

14. NAME OF HUSBAND OR WIFE JAMES BULLOCK (DECEASED)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Address LLOYD BULLOCK, 6227 WYOMING, ST. LOUIS, MO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH 10 hr

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Generalized arteriosclerosis — 5 yrs

DUE TO (c) 331x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1953, to 3-4-60 and last saw her/him alive on 3-4-60

Death occurred at 4:00 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) E H Wirthlin MD

22b. ADDRESS 5600 S Compton

22c. DATE SIGNED 3-5-60

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL

23b. DATE MARCH 6, 1960

23c. NAME OF CEMETERY OR CREMATORY KENNER CEMETERY

23d. LOCATION (City, town, or county) (State) DIXON (MARIES COUNTY) MISSOURI

24. FUNERAL DIRECTOR ADDRESS HOFFMEISTER COLONIAL MORTUARY ~~6464~~ CHIPPEWA STREET, ST. LOUIS, MO.

25. DATE RECD. BY LOCAL REG. MAR 5 1960

26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Lee E. Bramson

Signature of Student Embalmer

Licensed Embalmer No. 4769

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.