

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 26 1960

-60-034635

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 262

ENDED

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Boone</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>2 days</u>		c. CITY OR TOWN <u>Ashland</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If not hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #1</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) _____			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Florence</u> Last <u>Bullard</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1960</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/1887</u>	9. AGE (last birthday) <u>73</u>	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) <u>Dish-washer</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Ashland, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Edwin R. Bullard</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Francis White</u>			14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>State Hospital Records</u> Address <u>Fulton, Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Pneumonia</u>									
Arteriosclerosis									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.									
DUE TO (b) _____									
DUE TO (c) _____									
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>9/18/60</u> to <u>9/20/60</u> and last saw her <u>XXX</u> alive on <u>9/20/60</u> Death occurred at <u>1430 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>State Hospital #1</u> <u>Fulton, Mo.</u>			22c. DATE SIGNED <u>9/20/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Sept 22 60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Salem Cemetery</u>		23d. LOCATION (City, town, or county) <u>Ashland</u>		(State) <u>MO</u>		
24. FUNERAL DIRECTOR <u>Wm C. Burnett</u> ADDRESS <u>Ashland Mo</u>		25. DATE RECD. BY LOCAL REG. <u>20 Sept 1960</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 12 1968

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 _____
Signature of Student Embalmer

Signed LeRoy Claypool

Licensed Embalmer No. 4412

P. O. Address New Bloom

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (Failure to conform 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.