URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 1 1959

59-041481
STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. — Registrar's No. 445

ENDED

1. PLACE OF DEATH
a. COUNTY St. Francois
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RRT 2 FARMINGTON
Length of stay in 1b: 2 WKS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francois Twp. MINERAL AREA OSTEO
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Washington
c. CITY OR TOWN CALEDONIA
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First AGUSTA Middle — Last HULL

4. DATE OF DEATH: Month NOV Day 23, Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: APR. 5, 1872

9. AGE (last birthday): 87

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): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): UNKNOWN.

12. CITIZEN OF WHAT COUNTRY: USA.

13a. FATHER'S NAME: SAMUEL TULLOCK.

13b. MOTHER'S MAIDEN NAME: MARY SMITH

14. NAME OF HUSBAND OR WIFE: FRANK HULLS

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: Mrs Tom Davis Elvins, mo
Address

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)	Peripheral Circulatory Collapse	38 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Shock	38 hrs
DUE TO (c)	Ascending Saddle Thrombus	38 hrs.

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

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.): Fell @ Home.

20c. TIME OF INJURY: Hour — a.m. p.m. — Month 11 Day 11 Year 59

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.): Home

20f. CITY, TOWN, OR LOCATION: Caledonia COUNTY: Mo STATE:

21. I attended the deceased from 11/21/59, to 11/24/59 and last saw her/him alive on 11/23/59
Death occurred at 2:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Paul E. Boaz DO

22b. ADDRESS: Farmington Mo

22c. DATE SIGNED: 11/25/59

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

23b. DATE: NOV. 26, 1959

23c. NAME OF CEMETERY OR CREMATORY: PRESBYTERIAN

23d. LOCATION (City, town, or county) (State): CALEDONIA, MO.

24. FUNERAL DIRECTOR ADDRESS: R. CALDWELL 711 EAST MAIN ST. FLAT RIVER, MO.

25. DATE RECD. BY LOCAL REG.: NOV. 25, 1959

26. REGISTRAR'S SIGNATURE: Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DOCUMENT

STATEMENT BY LICENSED EMBALMER

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

or by Donald Dale Caldwell, Student Embalmer No. 587

working under my personal supervision.

Student Donald Dale Caldwell Signed R. Caldwell

Signature of Student Embalmer

Licensed Embalmer No. 2531

P. O. Address Flat Riv

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