WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Schuyler

Township: Prairie

or Village:

or City: (NO. ; St.; Ward)

Registration District No. 806 File No. 34277

Primary Registration District No. 6051 Registered No. 16

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James Monroe Fulcher.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

DATE OF BIRTH: November 26, 1844 (Month) (Day) (Year)

AGE: 69 yrs. 10 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Schuyler Co. Mo.

PARENTS
NAME OF FATHER: John S. Fulcher
BIRTHPLACE OF FATHER (City or town, State or foreign country): Boone Co. Mo.
MAIDEN NAME OF MOTHER: Mary Ann Alverson
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Madison Co. Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs Nancy Roberts.

(ADDRESS): Lancaster Mo

Filed Oct 23, 1914 W. H. Gieber REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct 22 (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from July 1, 1914, to Oct 22, 1914, that I last saw him alive on Oct 20, 1914, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency.
12 A

(Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) W. H. Gieber M. D.

Oct 23, 1914 (Address) Queen City Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bethel Cemetery	Oct 24, 1914
UNDERTAKER	**ADDRESS**
John A. Roberts	Lancaster

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.: _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH _____ (Month) _____ (Day), *1*_____ (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), *191*____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL _____, 191____

UNDERTAKER | ADDRESS