

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

Do not use this space.

37415

90

File No. _____
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County..... LAFAYETTE Registration District No. 461
Township Livingston Primary Registration District No. 5625
City HIGGINSVILLE (No. _____) St. _____ Ward _____

2. FULL NAME WILLIAM F. FOUNTAIN

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M	4. COLOR OR RACE W	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) WIDOWED
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) SEPT-17-1948

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
80-	2	12		

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) LAFAYETTE COUNTY
(STATE OR COUNTRY) MO.

PARENTS

10. NAME OF FATHER ALEXANDER FONTAIN

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) KENTUCKY

12. MAIDEN NAME OF MOTHER MARION NEVIN

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) SCOTLAND EDINBUROUGH.

14. INFORMANT Mr. James Carlisle Byrd
(Address) HIGGINSVILLE, MO.

15. File No. 110030-1928 J. D. Cape
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 29 1928

17. I HEREBY CERTIFY, That I attended deceased from Nov 28, 1928, to Nov 29, 1928, that I last saw him alive on Nov 28, 1928, and that death occurred, on the date stated above, at 7-2 A.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Arteriosclerosis
91B 29
91B 29
CONTRIBUTORY (SECONDARY) 91B
(duration) 29 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS By Dr. Hand M. D.

(Signed) Nov 30, 1928 (Address) Livingston Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL
7 LEX. MO.

DATE OF BURIAL
12-1-1928
E*L*L

20. UNDERTAKER
Hooper Memorial
ADDRESS
H*VILLE.

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.

1928

