

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

Do not use this space.

48573

**1. PLACE OF DEATH**

County Jackson Registration District No. 30  
 Township Haw Primary Registration District No. 3  
 City Kansas City (No. St Anthony Home) St. Ward

File No. \_\_\_\_\_  
 Registered No. 505  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Robert Lee Fulton  
 (a) Residence. No. St Anthony's Home St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-2-30

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
		<u>1</u>		

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K. C. Mo

10. NAME OF FATHER Ossie Nilmeth

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

12. MAIDEN NAME OF MOTHER Margaret Fulton  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Red Oak Iowa

14. INFORMANT Sister M. Joseph  
 (Address) St. Anthony's H. 237 College

15. FILED 3 19 30 M. M. Grothe  
 REGISTRAR Ans

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 2 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 to Feb 2 1930  
 that I last saw him alive on Feb 1, 1930, and that death occurred, on the date stated above, at 6:20 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Intracranial hemorrhage  
160B  
160B birth injury (duration) \_\_\_\_\_ ds \_\_\_\_\_  
160B Malnutrition (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds \_\_\_\_\_  
 CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED 160B  
 NOT AT PLACE OF DEATH? Yes  
 DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

19. WAS THERE AN AUTOPSY? No  
 WHAT TEST CONFIRMED DIAGNOSIS? Spinal puncture  
Examined  
 (Signed) H. Ormer M. D.  
 (Address) 2140 Med. Arts Bldg.

\*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 St Marys Cem. DATE OF BURIAL Feb 3 - 1930

20. UNDERTAKER Jahn W. Wagner ADDRESS 1409 Grand Ave

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.

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