

N. R.—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.

APR 30 1930

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

Do not use this space.

9088

**1. PLACE OF DEATH**

County Jackson  
 Township Prairie  
 City Jackson Co Home

Registration District No. 400  
 Primary Registration District No. 5552 B  
 (No. Jackson Co Home)

File No. 9088  
 Registered No. 54  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** James M. Fulton

(a) Residence. No. Jackson County 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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** Male    **4. COLOR OR RACE** white    **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** single  
(write the word)

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** single

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** 11-21-1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>73</u>	<u>4</u>	<u>4</u>	

**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work carpenter  
 (b) General nature of industry, business, or establishment in which employed (or employer) unknown  
 (c) Name of employer unknown

**9. BIRTHPLACE (CITY OR TOWN)** \_\_\_\_\_  
 (STATE OR COUNTRY) New York

**10. NAME OF FATHER** unknown

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)** \_\_\_\_\_  
 (STATE OR COUNTRY) unknown

**12. MAIDEN NAME OF MOTHER** unknown

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)** \_\_\_\_\_  
 (STATE OR COUNTRY) unknown

**14. INFORMANT** J. W. Hostetter  
 (Address) Jackson Co Home

**15. FILED** 1 1930 W. S. James  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 3-25-1930

**17. I HEREBY CERTIFY, That I attended deceased from** 3-10-1930 to 3-25-1930  
 that I last saw him alive on 3-24-1930 and that death occurred, on the date stated above, at 5:50 8 m.

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

mitral regurgitation  
97A  
9000  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
**CONTRIBUTORY (SECONDARY)**  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED** \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

**DID AN OPERATION PRECEDE DEATH?** No DATE OF \_\_\_\_\_  
**WAS THERE AN AUTOPSY?** No

**WHAT TEST CONFIRMED DIAGNOSIS?** Clinical  
 (Signed) J. H. Green, M. D.  
325, 1930 (Address) Doddsburg, 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** \_\_\_\_\_  
**DATE OF BURIAL** \_\_\_\_\_

**20. UNDERTAKER** Ketterlin  
**ADDRESS** Kellie

29  
2  
31

