

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

Do not use this space.

37789

File No. 10895
Registered No. _____
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis** (No. **Barnes Hospital**)

2. FULL NAME

Raymond B. Fulhorst
(a) Residence. No. **4718 Adams ave 15** Ward.

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 (write the word) **married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **March 29th 1903**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
27 - 7 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Chauffer**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer **Hyatt Bakery Co**

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **St. Louis**

10. NAME OF FATHER

Joseph Fulhorst

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **St. Louis**

12. MAIDEN NAME OF MOTHER

Francis Freitag

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Ills**

14. INFORMANT

Wallinga Fulhorst
(Address) **4718 Adams ave**

15. FILED

Nov 18 1930
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **11-16-1930**

17. I HEREBY CERTIFY, That I attended deceased from **11-14**, 19**30**, to **11-16**, 19**30**
that I last saw him alive on **11-16**, 19**30**, and that death occurred, on the date stated above, at **5:30 a. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of the lung, malignant.
178
1148 (duration) ? yrs. mos. ds.
CONTRIBUTORY **Pulmonary hemorrhage**
(SECONDARY) **from tumor** (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? **yes**

WHAT TEST CONFIRMED DIAGNOSIS **Post-mortem**

(Signed) **Franklin Efferton**, M. D.

Nov 16 1930 (Address) **600 Kingshighway**

*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

Calvary Cemetery

20. UNDERTAKER

Edward Hoch

DATE OF BURIAL

Nov 19- 1930

ADDRESS

3516 414th

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.

