

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

Do not use this space.

217

JAN 19 1931

1. PLACE OF DEATH
 County Buchanan Registration District No. 85
 Township _____ Primary Registration District No. 1001
 City St. Joseph Mo. (No. 1721 Bartlett St) St. _____ Ward _____

2. FULL NAME Walter James Fultz
 (a) Residence. No. 1721 Bartlett 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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 8, 1891

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>39</u>	<u>2</u>	<u>28</u>		

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

9. BIRTHPLACE (CITY OR TOWN) Missouri
 (STATE OR COUNTRY)

10. NAME OF FATHER Henry Fultz

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

12. MAIDEN NAME OF MOTHER Addie Brocky

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

PARENTS

14. INFORMANT Pearl Fultz
 (Address) 1721 Bartlett St

15. FILED John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7, 31 1931

17. I HEREBY CERTIFY, That I attended deceased from 7th of January, 1931, to 7th January, 1931 that I last saw him alive on 7th January, 1931, and that death occurred, on the date stated above, at 4:05 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage - Apoplexy

(duration) _____ yrs. _____ mos. 1 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

WHICH TEST CONFIRMED DIAGNOSIS? Clinical test
 (Signed) [Signature], M. D.

8 Jan. 19 31 (Address) 1908 Messanie Street
St. Joseph, Missouri

*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 <u>City Cemetery</u>	DATE OF BURIAL <u>1-20-31</u> 19 <u>31</u>
20. UNDERTAKER <u>B.F. Graves Funeral Home</u>	ADDRESS <u>806 S. 17 S</u>

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.

JAN 10 1931

