

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

Do not use this space.

*Dr. J. F. Fulbright*  
35449

**1. PLACE OF DEATH**

39 County Greene Registration District No. 318  
Township Maple Park Primary Registration District No. 5439  
City Springfield, Mo. St. Mo. Ward 6

File No. \_\_\_\_\_  
Registered No. 783  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. Rt. 6 St. Mo. 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 14, 1860  
7. AGE YEARS 72 MONTHS 8 DAYS 1 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Turner  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 1870-1911  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Greene Co. 1 (STATE OR COUNTRY) Missouri

13. NAME Ferry Fulbright

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) 31

15. MAIDEN NAME Abbie Bryant

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT Mrs. Mollie Fulbright (ADDRESS) Rt. 6

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Park DATE NOV 17 1932

19. UNDERTAKER Alma Lafayette (ADDRESS) Springfield Mo.

20. FILED 11-17 1932 R. W. Ferguson Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 15 1932

22. I HEREBY CERTIFY, That I attended deceased from 11/15 1932 to 11/15 1932

I last saw him alive on 11/15 1932 Death is said to have occurred on the date stated above, at 11 p. m.

The principal cause of death and related causes of importance were as follows:

accidental death  
fell from ceiling of  
balcony over of  
right cor. Date of onset \_\_\_\_\_

Other contributory causes of importance: 1860

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? Examination Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury 11/10 1932

Where did injury occur? at his home (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. Home

Manner of injury suicide to spine

Nature of injury fracture of skull

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_ If so, specify \_\_\_\_\_

(Signed) J. F. Fulbright M. D.  
(Address) Springfield Mo.

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.

JAN 9 1933

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