

LEAD APR 11 1939

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

10272
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway - 1 Registration District No. 104
 (b) Township Fulton Primary Registration District No. 3008 Registered No. 88
 (c) City Fulton (d) Street No. State Hosp. #1 Fulton Mo. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. 11 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

460 Tom Floree
 (a) Residence, No. Shelbyville Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) S

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-10-1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
68 68 6 14

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

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

FATHER 13. NAME Benjamin Floree

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

MOTHER 15. MAIDEN NAME Susan White

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

17. INFORMANT (ADDRESS) State Hospital #1 Records

18. BURIAL, CREMATION, OR REMOVAL PLACE S.O.D.S. Shelbyville DATE Mar 24, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. P. Thompson
Shelbyville Mo.

20. FILED Mar. 24, 1939 R. J. Crews
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/24/39

22. I HEREBY CERTIFY, That I attended deceased from 9 Mar, 13th, 1939 to Mar 24th, 1939

I last saw him alive on 3-23-1939. Death is said to have occurred on the date stated above, at 5:45 AM.
 The principal cause of death and related causes of importance were as follows:

Intercerebral (Coronary Occlusion) — 3/24/39
Hb

Other contributory causes of importance:
Psychosis with cerebral arteriosclerosis
1. Cancer of head of pancreas

Name of operation _____ Date of _____
 What test confirmed diagnosis Biopsy Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) R. J. Crews
106 (Address) State Hosp. #1 Fulton 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.

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22

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.