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.

X14028

REC'D JUN 8 1939

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

17488
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township Kaw — Primary Registration District No. 1002 — Registered No. 1890
(c) City Kansas City, Mo. — (d) Street No. St. Joseph Hospital, K.C.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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 435 Mary Elizabeth Fulton,
(a) Residence, No. R.R. #2. 66th, & Cambridge, St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 13th, 1861

7. AGE: YEARS 77 — MONTHS 9 — DAYS 20 — If LESS than 1 day, ...hrs. or ....min.

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. At Home
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) Indiana

FATHER
13. NAME Samuel Dailey,
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

MOTHER
15. MAIDEN NAME Lucinda Merriman,
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Harry Fulton, 66th, and Cambridge R.F.D. #2.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. Washington DATE May 5th, 1939

19. FUNERAL DIRECTOR (NAME) Mrs. C. L. Forster
(ADDRESS) 918 Brooklyn Avenue, K.C.Mo.

20. FILED May 5, 1939 M. M. [illegible]
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 3rd, 1939

22. I HEREBY CERTIFY, That I attended deceased from 2/1, 1929, to 5/3, 1939
I last saw her alive on 5/3, 1939. Death is said to have occurred on the date stated above, at 8; P.M. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Ch Myocarditis with Enlarged Heart.	
Ch Nephritis	
Hypertension	131

Other contributory causes of importance:
Senility. Anemia

Name of operation ..... Date of 5/4/39
What test confirmed diagnosis? Clinical Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... 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? .....
If so, specify .....
(Signed) [illegible] M. D.
(Address) 10307 Indep ave. K.C. Mo

(Licensed Embalmer's Statement on Reverse Side)

Dr. Gilmore, C. Stewart, 1o307 Indp. Av.

Phone--Indp. 4018

4 P. M.

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.