

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.

1939 4 10 20

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

34950
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. 3925

(c) City K.C. Mo. (d) Street No. General Hospital # 2 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. 4:25

2. PRINT FULL NAME John Fulchner

(a) Residence, No. 1622 St. Louis 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 male

4. COLOR OR RACE Colored

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-15-1878

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>61</u>	<u>8</u>	<u>22</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as saw mill, bank, etc.

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) Berger, Mo.

FATHER

13. NAME John Fulchner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Berger, Mo.

MOTHER

15. MAIDEN NAME Harriett

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Berger, Mo.

17. INFORMANT (ADDRESS) Record Clerk

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Hill DATE 10-12-1939

19. FUNERAL DIRECTOR (ADDRESS) K.C. Emb. &asket Co. 4140 State Ave. K.C.

20. FILED 10-11-39 mmbarne Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-7-1939

22. I HEREBY CERTIFY, That I attended deceased from 10-5-1939 to 10-7-1939

I last saw him alive on 10-7-1939 Death is said to have occurred on the date stated above, at 5:00 p.m.

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

Cerebral Hemorrhage
Hypertension

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? no

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) J. C. Thomas M. D.
(Address) General Hospital #2

STATEMENT BY LICENSED EMBALMER

I, Eugene English, Licensed Embalmer No. 3748
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Eugene English
L. E.
No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Eugene English
Licensed Embalmer No. 3748

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.)