

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **16322**

Registration District No. **852**

Primary Registration District No. **6121**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Sullivan Mo.  
 (b) City or town Rural  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Duncan Exp.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: \_\_\_\_\_ in hospital or institution (Specify whether)  
 In this community Life time  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Sullivan  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. N. W. Browning Mo  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Norma Adelaide Fuller

3. (b) If veteran, name war  3. (c) Social Security No.

20. DATE OF DEATH: Month April day 24  
 year 1940 hour 8:30 am minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Jan 27 to April 24, 1940, that I last saw her alive on April 30, 1940, and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white  
 6. (a) Single, widowed, married, divorced single  
 6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive  years  
 7. Birth date of deceased Sept 23 1879  
 (Month) (Day) (Year)

Immediate cause of death: Carcinoma of lung  
 Due to Carcinoma right chest  
 Due to \_\_\_\_\_

Duration  
3 years  
10 years

8. AGE: Years 60 Months 7 Days 1  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions Carcinomatous  
 (Include pregnancy within 3 months of death)

9. Birthplace Sullivan Co Mo  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farming

Major findings: 17  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 12. Name Gayton W. Fuller  
 13. Birthplace Mass.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Maria Anderson  
 15. Birthplace Virginia  
 (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? 76 A  
 (Specify type of place) While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

16. (a) Informant's own signature Mrs. Jean Ellen  
 (b) Address Browning Mo

17. (a) Burial (b) Date thereof April 26 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Harper Cem

18. (a) Signature of funeral director PK Payne  
 (b) Address Garret Mo

19. (a) April 26 1940 (b) Geo Hagan  
 (Date received local registrar) (Registrar's signature)

23. Signature J. R. McArthur (M. D. or other)  
 Address Browning Mo Date signed 4/24/40

WHILE PLAINLY USE UNFADING BLACK INK—MAKE 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.

RECEIVED

District Health Officer No. 10

District File Number 5-40-1012

Date Filed MAY 14 1940

SEP 1 1940

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 P. K. Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt mo

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.