

No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24448**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **3058**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: **Jackson**
 (a) County **Jackson**
 (b) City or town **Kansas City Mo.**
 (c) Name of hospital or institution: **Research Hospital.**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **5 Mos.**
 In this community **5 Mos.**
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City Mo.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **3440 Bellefontain Ave.**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME **Mrs. Amanda E. FULLER.**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **F. H. Fuller** 6. (c) Age of husband or wife if alive **23, 1862.** years

7. Birth date of deceased **November 23, 1862.**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	77	8	7	hr. min.

9. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business

12. Name **John J. Black.**

13. Birthplace **Illinois**
(State or foreign country)

14. Maiden name **Sarah Browning**

15. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **F. H. Fuller, Jr.**

(b) Address **3440 Bellefontain Ave.**

17. (a) **Removal** (b) Date thereof **7/31/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Denver Illinois**

18. (a) Signature of funeral director **Melody-McGilley.**
Kansas City Mo.

(b) Address
19. (a) **July 31, 1940** (b) **M-M-Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **30th**
year **1940** hour minute M.

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

Immediate cause of death **Carcinoma base**

Due to **Carcinoma of Rectum**

Due to **- 4/2**

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations **Metastases to
meninges & liver**
Of autopsy " "

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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?

While at work? (Specify type of place) (e) Means of injury **!**

23. Signature **F B Campbell** (M. D. or other) **MD.**

Address **Kansas City Mo** Date signed **7-31-40**

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. 267
working under my personal supervision.

Signed Ray E. Linn
Licensed Embalmer No. 2560
P. O. Address 1807 E 29th

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, fact should be so stated above.