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13-40  
7-39  
X23159

Registration District No. \_\_\_\_\_

Primary Registration District No. 3008

Registrar's No. 301

FILED DEC 17 1940

1. PLACE OF DEATH:

(a) County Callaway  
(b) City or town Fulton  
(c) Name of hospital or institution: State Hospital #1 Fulton, Mo.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Approx 4 mos 14 days  
(Specify whether) 30  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew  
(c) City or town Mexico (Rural)  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14<sup>th</sup>  
year 1940 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from 11-1, 1940, to 11-14, 1940  
that I last saw him alive on 11-14, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Myocarditis

Due to Senility

Due to R.A.C.

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (specify) no.

(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? no.

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Dr. F. Wood King (M. D. or other) MD  
Address State Hosp #1 Fulton Mo Date signed 11/14/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULLNAME Lloyd Mc Intosh

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 25 (Month) (Day) (Year) (H)

8. AGE: Years Months Days If less than one day  
95 (approx) 02 02 0 hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business ?

12. Name DK

13. Birthplace (City, town, or county) (State or foreign country) DK

14. Maiden name DK

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

16. (a) Informant State Hosp #1  
(b) Address Fulton Mo

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (c) Place: burial or cremation maie mo

18. (a) Signature of funeral director H.A. Puck L Son  
(b) Address maie mo

19. (a) 11-14-40 (b) R.N. Crews  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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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, fact should be so stated above.**