

REG. AUG 18 1941 827  
Registration District No. 827

Primary Registration District No. 4500

State File No. \_\_\_\_\_

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Shelby  
(b) City or town Clarence mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby 102  
(c) City or town Clarence mo Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 10 miles Northwest of town  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7th day 4th  
year 1941 hour 10 minute 35 P.M.

21. I hereby certify that I attended the deceased from June 23, 1941, to July 4, 1941;  
that I last saw her alive on July 4th, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial Pneumonia

Duration

Due to Streptococcus infection of throat and Bronchi

Due to Malnutrition

Other conditions: Intestinal Toxemia  
(Include pregnancy within 3 months of death)

Meningitis

PHYSICIAN

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

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 Dr. B. L. Edrington (M.D. or other) P.O.  
Address Clarence, Mo. Date signed July 21

3. (a) PRINT FULL NAME Betty Lou Fuller

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased March 24 - 1941  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 3 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Malco Co (City, town, or county) 0 Mo (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Noble Fuller

13. Birthplace Warren O Mo (City, town, or county) (State or foreign country)

14. Maiden name Ruth Langford

15. Birthplace Shelby Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Earl Fuller

(b) Address Clarence mo

17. (a) Burial (b) Date thereof 7/5-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Zion

18. (a) Signature of funeral director Medford Barber  
(b) Address Clarence mo

19. (a) July 22-41 (b) Ray Hammett  
(Date received by registrar) (Registrar's signature)

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

RECEIVED

District Health Officer No. 10

District File Number 8-41-1457

Date Filed AUG 13 1941

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 Kerry T. Parkellee

Licensed Embalmer No. 3835

P. O. Address Delburn Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.