

No. 2
1-4-41
17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37529

State File No. _____

DEC 22 1943 99

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4324

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K. C. General Hosp. #10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether
In this community 3 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. Helping Hand Institute
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ROBERT FULLBRIGHT

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

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

7. Birth date of deceased July 9 1908
(Month) (Day) (Year)

8. AGE: Years 33 Months 4 Days 12 If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business _____

12. Name Robert Fullbright

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

14. Maiden name Mary E. Jones

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

16. (a) Informant Mrs. Lottie Pousley

(b) Address 1216 S. Main; Ind. p. Mo.

17. (a) Removal (b) Date thereof 11 22 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty, Missouri

18. (a) Signature of funeral director Church Arthur

(b) Address Liberty, Missouri

19. (a) 11-22-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 21 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 3:55 P. to _____ 19____; that I saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Subarachnoid and intracerebral

Due to central hemorrhage

traumatic injury to head &

auto traumatism

Other conditions (Include pregnancy within 3 months of death) 1700

Major findings: Of operations _____

Of autopsy yes

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident 024

(b) Date of occurrence 11-22-41

(c) Where did injury occur? U.S. Highway #169 Clay Co. Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Yes

(Specify type of place) _____ (e) Means of injury Auto Trauma

23. Signature Joseph H. Smith (M. D. or other) _____

Address 15 - P. MO. Date signed _____

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

MOTHER FATHER

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.....

Blaine E. Weiler

Licensed Embalmer No.....

4075

P. O. Address.....

2332 W. Maple Pl.

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.