

FILED JUL 19 1943

Registration District No. 379

Primary Registration District No. 6277

State File No. _____

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Hartsville, Boone township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether _____)
In this community 1 yr 6 mo. 17 days
years, months or days

3. (a) PRINT FULL NAME Jarvis Fullington

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

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced 1

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

7. Birth date of deceased Dec 11 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 6 17 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Joe Fullington
13. Birthplace Hartsville Mo
(City, town, or county) (State or foreign country)
14. Maiden name Harvey Fullington
15. Birthplace Hartsville Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joe Fullington
(b) Address Hartsville Mo.

17. (a) Burial (b) Date thereof 6-29-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Pleasant Hill Cem

18. (a) Signature of funeral director Walter P. Bussan
(b) Address Hartsville Mo

19. (a) 6-29-43 (b) W. J. Young
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wright
(c) City or town Hartsville Rural, Boone township
(If outside city or town limits, write "RURAL")
(d) Street No. Rt. 1
(If rural, give location)
(e) If foreign born, how long in U. S. A. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28
year 1943 hour 9 minutes 30 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on 9:30 P.M. 6-28-43
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____

Due to No Medical Attendant
Physician Available

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy no

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 Joe Fullington Father
Address Hartsville Mo. Rt. 1 Date signed 6-29

PHYSICIAN
Underline the cause to which death should be charged statistically

WHILE PLAINLY—USE UNFADING 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. 6,

District File Number 743-853

Date Filed JUL 16 1943

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, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHJuly
State File No.Registration District No. 370Primary Registration District No. 6277Registrar's No. 19

1. PLACE OF DEATH:

- (a) County Wright
 (b) City or town Rural Boone 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)3. (a) PRINT
FULL NAMEJanneti Fullington3. (b) If veteran,
name war3. (c) Social Security
No.4. Sex F5. Color or
race W6. (a) Single, widowed, married,
divorced S

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if
alive..... Years7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

Unless than one day

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

(City, town, or county)

(State or foreign country)

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(b) Date thereof

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 8
year 1943 at 8 o'clock PM M.21. I hereby certify that I attended the deceased from
....., 19.....; and that death occurred on the date and hour stated above.Immediate cause of death.....
DurationNo medical attendant available

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations.....

Of autopsy.....

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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..... (M. D. or other)
Address..... Date signed.....

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

MOTHER FATHER

SUPPLEMENTARY

S-26423