

FILED SEP 10 1943

Registration District No. 7

Primary Registration District No. 3008

212

14
1
2

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

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp. No. 12
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 1/2 days
(Specify whether

In this community
years, months or days)

3. (a) PRINT FULL NAME

John F. Muldown

3. (b) If veteran,
name war.

3. (c) Social Security
No.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married Divorced

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

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 80 Months 7 Days 2

If less than one day
hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Mr. Orr

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

14. Maiden name Record

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

16. (a) Informant Record

(b) Address

17. (a) Burial (b) Date thereof 8-14-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Record

18. (a) Signature of funeral director H. B. Wade

(b) Address 112 Grand Ave Fulton Mo

19. (a) 8-13-1943 (b) John Morosoff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Callaway
(c) City or town Fulton
(If outside city or town limits, write "RURAL")
(d) Street No. 2
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12
year 1943 hour 40 minutes 50 A.M.

21. I hereby certify that I attended the deceased from 7-27-1943 to 8-11-1943
that I last saw alive on 8-11-1943
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary artery atherosclerosis
myocarditis
hypertension

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
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 X. E. Sherrill (M. D. or other)
Address Fulton Mo Date 8/12/43

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.