V. S. No. 2
30M—9-4-41
Rev. 5-17-39
I X29484

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 9 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14300

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 128

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. #1 O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since July 23-1940 (Specify whether
In this community 3 yrs 9 mo. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St Louis
(c) City or town St Louis City 14
(If outside city or town limits, write "RURAL")
(d) Street No. 625 Holly Ave 1
(If rural, give location)
(e) Citizen of ~~foreign country~~? Born U.S. of A 20 (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME John Fountain
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male
5. Color or race Negro
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 25 (Day) 1886 (Year)

8. AGE: Years	Months	Days	If less than one day
57	10	14	hr. min.

9. Birthplace Winfield (City, town, or county) Mo. O (State or foreign country)
10. Usual occupation night watchman
11. Industry or business cant say
FATHER
12. Name James Fountain
13. Birthplace Winfield (City, town, or county) Mo. O (State or foreign country)
MOTHER
14. Maiden name Lorenda Williams
15. Birthplace Winfield (City, town, or county) Mo. O (State or foreign country)
16. (a) Informant Hosp. records
(b) Address
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 (Month) 13 (Day) 1944 (Year)
(c) Place: burial or cremation Washington Park Cem
18. (a) Signature of funeral director [illegible]
(b) Address 3615 Eastonan [illegible]
19. (a) 4-9-1944 (Date received local registrar) (b) Josie Morrison (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8 year 1944 hour 6 minute 30 P. M.
21. I hereby certify that I and other members of Hosp. Staff attended the deceased from July 23, 1940, to April 8, 1944 that I last saw him alive on April 8, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Central nervous system & Syphilis (Paresis)	
Due to	
Due to	
Other conditions General physical and mental deterioration (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 30	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature P. S. Tate (M. D. or other)
Address State Hosp. #1 Date signed 4-8-44

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 5-8-44

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 myself, Registered Apprentice No. , working under my personal supervision.

Signed [illegible]

Licensed Embalmer No. [illegible]

P. O. Address 2812 Forest St Louis, Mo

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.