

Registration District No. 276

Primary Registration District No. 4410

1. PLACE OF DEATH

(a) County Phelps
(b) City or town St James
(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 MI (b) County Phelps
(c) City or town St James
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 18
year 1944 hour 12:35 minute 0 M.
21. I hereby certify that I attended the deceased from Jan
1944 to Apr 18, 1944
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death acute nephritis
Due to Chronic Hypertension
Duration 2 wks
10 yrs

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 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 William H. Brewer (M. D. or other) _____
Address _____ Date signed _____

3. (a) PRINT FULL NAME Chas H Fulbright
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race W
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Pearl Fulbright
(c) Age of husband or wife if alive 46 years
7. Birth date of deceased 10-3-1865
(Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days 15
If less than one day _____ hr. _____ min.

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

10. Usual occupation Medical Physician

11. Industry or business _____

MOTHER FATHER
12. Name John Fulbright
13. Birthplace Mo
(City, town, or county) (State or foreign country)
14. Maiden name Rubeece Parker
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Pearl Fulbright
(b) Address St James Mo
17. (a) Rural (b) Date thereof 4-21-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Home Cem

18. (a) Signature of funeral director W. H. Richler
(b) Address St James Mo
19. (a) 5-5-1944 (b) Charles Dickson
(Data received from registrar) (Registrar's signature)

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

1130

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

W. L. Licklider

Licensed Embalmer No.

1970

P. O. Address

St. James 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, above space should be left blank.

Registration District No. 276

Primary Registration District No. 4410

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town James
(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 NAME Chas H. Fulbright

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

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

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

7. Birth date of deceased Jan 10 (Month) (Day) (Year)

8. AGE: Years 22 Months 1 Days _____ (Unless than one day) min.

9. Birthplace Overtone (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 _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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 April day 18 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death acute hepatitis Duration _____

Due to chronic hypertension

Due to chronic nephritis and prostatitis

Other conditions with urea (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 1218

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

25

18878

DEPARTMENT
OF COMMERCE
1944 JUN 13 PM 3 45
CHIEF CLERK