

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1864
Registrar's No. 425

FILED JAN 20 1945

Registration District No. 27 Primary Registration District No. 3008

4
2

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton

(c) Name of hospital or institution State Hospital No. 1
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 2 m 23 d
(If not in hospital or institution, write street number or location) (Specify whether years, months or days)

In this community 2 m 23 d

3. (a) PRINT FULL NAME Francis Thurmon Wharton

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, Separated

6. (b) Name of husband or wife Emma M Wharton

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

7. Birth date of deceased. Dec 3 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>0</u>	<u>23</u>	hr. min.

9. Birthplace Green Ridge Mo. M
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name F. M. Wharton

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

14. Maiden name Emma Elizabeth

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

16. (a) Informant Record

(b) Address _____

17. (a) Removal (b) Date thereof 12-30-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation La Monte res.

18. (a) Signature of funeral director B. F. Parker

(b) Address La Monte res.

19. (a) 12-30-1944 (b) Josie Marsinkoff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis

(c) City or town Sedalia
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 25
year 1944 hour 10-40 minute 0 M.

21. I hereby certify that I attended the deceased from 12-20-1944 to 12-28-1944
that I last saw him alive on 12-28-1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Meningitis

Due to Stroke

Other conditions 300
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy Cerebral Hemorrhage

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)
(b) Means of injury Stroke

23. Signature George W. [Signature] (M. D. or other) M.D.
Address Fulton Mo Date signed 12-28-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 1-19-45

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 B. F. Parker

Licensed Embalmer No. 1592

P. O. Address La Monte 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.