

V. S. No. 2
FORM-8-43
Rev. 5-17-39
I X37823

15912

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 180

FILED JUN 10 1946

Registration District No. 7 Primary Registration District No. 3008

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 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11-2-43
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Clarence Fulton
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex M 5. Color or race negro
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Marie Fulton
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 20 1907
(Month) (Day) (Year)

8. AGE: Years 38 Months _____ Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation DL

11. Industry or business _____

12. Name Robert Fulton
13. Birthplace DL (City, town, or county) (State or foreign country)
14. Maiden name DL
15. Birthplace DL (City, town, or county) (State or foreign country)

16. (a) Informant Records
(b) Address _____

17. (a) Removal (b) Date thereof 5/5/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bome June

18. (a) Signature of funeral director Shallace Funeral Home
(b) Address 776 6th St Fulton, Mo

19. (a) 5-5-1946 (b) Joel Moreschoff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County St. Francis
(c) City or town Room 14
(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 May day 4
year 1946 hour _____ minute 10 P. M.
21. I hereby certify that I attended the deceased from 4-15 to 5-4 1946
that I last saw him alive on 5-4 1946
and that death occurred on the date and hour stated above.

Immediate cause of death pulmonary tuberculosis Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 13th

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? _____

Write at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature W. E. Starnell (M. D. of this State)
Address Fulton md Date 5/5/46

JUN 10 1946

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 6-8-46

NOV 19 1956

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 Denzil C. Browning
Licensed Embalmer No. 2724
P. O. Address Fulton 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.