

FILED JUL 10 1947

State File No. _____

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 237

1. PLACE OF DEATH:
 (a) County Callaway
Fulton
 (b) City or town
 (c) Name of hospital or institution: Callaway County Hospital
 (If not in hospital or institution, write street number and location)
 (d) Length of stay: In hospital or institution 3 Days
 In this community 56 Years
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Callaway
 (c) City or town Fulton
 (d) Street No. 100 Ravine
 (e) Citizen of foreign country? No
 If yes, name country _____

3. (a) PRINT FULL NAME Fannie Castleman Hill

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Sept 10 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 9 20 _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John A. Castleman

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

14. Maiden name Lizzie Carter

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

16. (a) Informant Mrs. J. H. Crump

(b) Address 100 Ravine St, Fulton, Missouri

17. (a) Burial (b) Date thereof 7-2-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Unity Baptist Cem.

18. (a) Signature of funeral director Hallace Funeral Home
6th St, Fulton, Missouri

19. (a) 7-2-1947 (b) Joan Morrison
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30
year 1947 hour 12 minute 10 P.M.

21. I hereby certify that I attended the deceased from 6/25 1947 to 6/30 1947
that I last saw her alive on 6/30 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchitis pneumonia Duration 24 hrs

Due to Cerebral (Accident) hemorrhage - on right

Due to Gen. arteriosclerosis with hypertension

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

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(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 George Wood (M. D. or other) MD
Address Fulton Mo. Date signed 7/2/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

4
2

Date Filed 7/9/47

District File Number

District Health Officer No. 9

RECEIVED

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 Wenzil R. Browning

Licensed Embalmer No. 2724

P. O. Address Fulton St.

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.