S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 26 1947

Registration District No. ____

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26637

Primary Registration District No. 3000

Registrar's No. 221

1. PLACE OF DEATH:
(a) County ADAIR
(b) City or town KIRKSVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: NURSING HOME #1 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community 3 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 114
(c) City or town MOUNTAIN GROVE Mo
(If outside city or town limits, write "RURAL")
(d) Street No. ____ 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME LOLA M. FULK
3. (b) If veteran, name war ____
3. (c) Social Security No. ____

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Oct. (Month) 3 (Day) 1873 (Year)

8. AGE: Years 73 | Months 10 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace SCOTLAND Co MO. (City, town, or county) (State or foreign country)
10. Usual occupation SCHOOL TEACHER
11. Industry or business ____
MOTHER FATHER
12. Name H.B. FULK
13. Birthplace OHIO (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name CELESTIA SPRAGUE
15. Birthplace SCOTLAND Co. Mo (City, town, or county) (State or foreign country)
16. (a) Informant Walter Fulk
(b) Address Arbela Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-11-1947 (Month) (Day) (Year)
(c) Place: burial or cremation MEMPHIS CEMETERY
18. (a) Signature of funeral director H.W. Payne & Sons
(b) Address Memphis, Mo
19. (a) 8-16-47 (Date received local registrar) (b) Hale Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9 year 1947 hour 11 minute 10 P M.
21. I hereby certify that I attended the deceased from Feb 6, 1947, to Aug 9, 1947, that I last saw her alive on Aug 19, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary occlusion — Duration: 1 min.
Due to: Arteriosclerosis — years
Due to: ____
Other conditions (Include pregnancy within 3 months of death): Pernicious Anemia
Major findings: Paralysis agitans
Of operations: ____
Of autopsy: 9 47

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 2

23. Signature M.T. Gatewood (M.D. or other) M.D.
Address Kirksville, Mo. Date signed 8-9-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 8-47-1097
Date Filed AUG 25 1947

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 Neal Payne

Licensed Embalmer No. 2550

P. O. Address Memphis, 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.