

FILED AUG 30 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26960

State File No. _____

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 294

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hosp. # 1 2
(If not in hospital of institution, write street number or location)
(d) Length of stay: In hospital or institution Since 9-3-1936
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Eldon Mabuce

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

4. Sex M.D 5. Color or race W. 6. (a) Single, widowed, married, divorced S.O

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

7. Birth date of deceased 3 14 1904
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>43</u>	<u>5</u>	<u>2</u>	hr. _____ min. <u>6</u>

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

10. Usual occupation Janitor

11. Industry or business _____

12. Name E. P. Mabuce

13. Birthplace Danmark 4
(City, town, or county) (State or foreign country)

14. Maiden name Marcella Ferguson

15. Birthplace Mo. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Fulton Mo.

17. (a) Removal (b) Date thereof 8-16-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flat River, Mo.

18. (e) Signature of funeral director Wallace Funeral Home

(b) Address 7th & 6th St. Fulton, Missouri

19. (a) 8-16-1947 (b) J. M. M... 29
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Francois 14
(c) City or town Flat River 2
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? N.D. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16
year 1947 hour 15 minute _____ A. M.

21. I hereby certify that I attended the deceased from Oct. 1-46 19____, to Aug. 16-47 19____
that I last saw him alive on 8-15-47 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis.

Due to _____

Due to _____

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

Major findings: Of operations B B

Of autopsy _____

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? 0

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

23. Signature E. P. Price (M.D. or other)

Address Fulton Mo

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed AUG 29 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 *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.