

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

FILED SEP 9 1947

State File No. _____

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 262

16
4

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

1. PLACE OF DEATH:

(a) County: Cape Girardeau

(b) City or town: Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Southeast Missouri
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days
(Specify whether years, months or days)

In this community 6 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME: William Fountain Fulbright

3. (b) If veteran, name war: _____

3. (c) Social Security No. _____

4. Sex: Male

5. Color or race: W

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife: ANNIE-MAY FULBRIGHT

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

7. Birth date of deceased: APR 17 1882
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
65	2	17	hr. _____ min.

9. Birthplace: Cape Co. MO
(City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: FARMER

MOTHER FATHER

12. Name: CHARLES E. FULBRIGHT

13. Birthplace: CAPE-CO MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name: FRANCIS-STARKER

15. Birthplace: CAPE-CO MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant: MRS. GRACE FARLAND

(b) Address: BESSVILLE MO

17. (a) Burial (b) Date thereof: APR 29 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: BESS-CEMETERY

18. (a) Signature of funeral director: _____

(b) Address: _____

19. (a) 9-3-1947 (b) C. C. Sumner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Bollinger

(c) City or town: Scopus Rural
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27
year 1947 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from 6/17 1946 to 6/27 1947
that I last saw him alive on 6/27 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral thrombosis

Due to: 7th hypertension

Due to: Arterio sclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations: 837

Of autopsy: _____

Duration

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 _____

23. Signature: O. K. ... (M. D. or ...)

Address: Cape Girardeau Date signed: _____

RECEIVED

Health Officer No. 4

Number 947-1154

9-8-47

Handwritten notes

Handwritten notes

Handwritten notes

Handwritten notes

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.....

M. Embalmer Family Reject, Registered Apprentice No.....
working under my personal supervision.

Signed *V*.....

Licensed Embalmer No.....

P. O. Address.....

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.