

S. No. 2
M-8-43
v. 5-17-39
P. 1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35144**
Registrar's No. **45**

Registration District No. **243**

Primary Registration District No. **4364**

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

1. PLACE OF DEATH:

(a) County **Newton**

(b) City or town **Stella, Mo**
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **McDonald**

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

(d) Street No. **Rocky Comfort, Mo.**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Samuel Arthur Fullerton**

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 **Married**

6. (b) Name of husband or wife **Perna Fullerton** 6. (c) Age of husband or wife if alive **47** years

7. Birth date of deceased **September 6 1880**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	67	1	9	hr. _____ min. _____

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

10. Usual occupation **Farming**

11. Industry or business _____

12. Name **Samuel Fullerton**

13. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

14. Maiden name **Marie Fullerton**

15. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Perna Fullerton**
(b) Address **Rocky Comfort, Mo.**

17. (a) **Removal** (b) Date thereof **Oct. 18-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Pleasant Hope Mo.**

18. (a) Signature of funeral director **W. M. Payne**
(b) Address **Wheaton, Mo.**

19. (a) **11-2 1947** (b) **Alpha Dyer**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **15**
year **1947** hour **4** minute **P.M.**

21. I hereby certify that I attended the deceased from **October 13 1947** to **October 15 1947**
and that death occurred on the date and hour stated above.

that I last saw him alive on **October 15 1947**

Immediate cause of death **Angina Pectoris** Duration **2 days**

Due to _____

Due to _____

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

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? _____

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

23. Signature **Cardwell** (M. D. or _____)
Address **Stella, Mo** Date signed **10-17-47**

OCT 8 1952

RECEIVED

District Health Officer No. Newton
District File Number 447-299
Date Filed 11-12-47

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

Wm. M. Logue

Licensed Embalmer No. 3942

P. O. Address Newton, 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.