

No. 300
10.48

FILED MAR 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. **12E** PRIMARY REG. DIST. NO. **2000** Registrar's No. **159-A**

39
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Park	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Highway - Rural	
c. LENGTH OF STAY (In this place) 2 1/2 mo		d. STREET ADDRESS (If rural, give location) RR 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Roger	b. (Middle) Dee	c. (Last) Fuller	4. DATE OF DEATH (Month) (Day) (Year) Feb. 18 1949
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5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH June 10, 1947	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME John Fuller Jr.	13b. MOTHER'S MAIDEN NAME Edna M Standley	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Margaret Fuller	ADDRESS Highway 2nd
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis Tuberculous		2 1/2 mo
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Dehydration Convulsions		0 10	1 wk 1 wk

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12-3 1948**, to **2-18 1949**, that I last saw the deceased alive on **2-18 1949**, and that death occurred at **8:30 P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Urban Beeseck MD	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 2-18-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-20-49	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery S.W. Park of Balaun Mo	24d. LOCATION (City, town, or county) (State)
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BATE REC'D BY LOCAL REG. 3/4/49	REGISTRAR'S SIGNATURE W.E. Standley MD	25. FUNERAL DIRECTOR'S SIGNATURE W.E. Standley MD	ADDRESS 1401
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- 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 _____

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working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed *Edward B. Carver*

Licensed Embalmer No. *3082*

P. O. Address *Bolivar 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.