

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6578

BIRTH NO. _____		REG. DIST. NO. <b>318</b>	PRIMARY REG. DIST. NO. <b>1003</b>	Registrar's No. <b>1509</b>
1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Labette</b>		
b. CITY OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Parsons</b>		
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS <b>1624 Appeton</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Johns Hospital</b>		e. (If rural, give location) _____		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Frederick</b>		b. (Middle) <b>W.</b>		c. (Last) <b>Pulcher</b>
4. DATE OF DEATH (Month) (Day) (Year) <b>2 16 1949</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>Sept. 3, 1892</b>	9. AGE (In years last birthday) <b>56</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>M.K.T. R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Brookfield, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13a. FATHER'S NAME <b>John Pulcher</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Savage</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War</b>		16. SOCIAL SECURITY NO. <b>702-10-0379</b>		17. INFORMANT'S SIGNATURE OR NAME <b>W.R. Pulcher, Parsons, Kansas.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>generalized Peritonitis</b>		DUE TO (b) <b>Carcinoma of Cecum</b>		<b>10 days</b>
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <b>H<sub>2</sub>O</b>		<b>10 months</b>
II. OTHER SIGNIFICANT CONDITIONS		Prostatic hypertrophy		
Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION <b>2-1-49</b>	19b. MAJOR FINDINGS OF OPERATION <b>Large Carcinoma of Cecum</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE <b>no</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <b>2-1, 1949</b> to <b>2-16, 1949</b> , that I last saw the deceased alive on <b>2-15, 1949</b> , and that death occurred at <b>12:20 A.M.</b> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <b>D. J. Verba M.D.</b>		23b. ADDRESS <b>Sister Bldg</b>		23c. DATE SIGNED <b>2-16-49</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>2-16-49</b>	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) <b>Parsons, Kansas.</b>	
DATE REC'D BY LOCAL REG. <b>FEB</b>	REGISTRAR'S SIGNATURE <b>J. B. Lasater</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>		

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Clement McKeary*

Licensed Embalmer No. 3732

P. O. Address St. Louis

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.