

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22983

State File No. \_\_\_\_\_

**35**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 107 PRIMARY REG. DIST. NO. 3014 Registrar's No. 95

1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>DeKalb</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kennett</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kennett</u>	
c. LENGTH OF STAY (in this place) <u>Yes</u>		35	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>905 E. 4th Street</u>		d. STREET ADDRESS (If rural, give location) <u>905 E. 4th St</u>	
3. NAME OF DECEASED a. (First) <u>William Harrison</u> b. (Middle) <u>Fuller</u> c. (Last) <u>Fuller</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 6 1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 22, 1867</u>
9. AGE (In years last birthday) <u>82</u>		10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>
11. BIRTH PLACE (State or foreign country) <u>Knott Co. Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Matthew Fuller</u>		13b. MOTHER'S MARDEN NAME <u>D. Know</u>	
14. NAME OF HUSBAND OR WIFE <u>Deceased Fannie Long</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>089-10-8212</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Della Bailey</u> ADDRESS <u>Kennett</u>	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiovascular Disease</u> ANTECEDENT CAUSES. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>3 1/2 days</u> , 19 <u>49</u> , to <u>5 days</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>4 days</u> , 19 <u>49</u> , and that death occurred at <u>9:17</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>James C. Cook M.D.</u> (Degree or title)		23b. ADDRESS <u>Kennett Mo</u>	
23c. DATE SIGNED <u>Aug 4 1949</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	
24b. DATE <u>Aug 7, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hazel Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>Kennett, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. N. Bailey</u> ADDRESS <u>Reston, Ark.</u>	
DATE REC'D BY LOCAL REG. <u>Aug 6-1949</u>		REGISTRAR'S SIGNATURE <u>Carl H. Harrison</u> 90	

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

RECEIVED AUG 10 19

District Health Office No. 2

District File Number 849-815

Date Filed

*Handwritten notes and signatures, including names like William Thomas and dates like 8/10/19.*

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.

Signed

*Handwritten signature of Dan W. McBride*

Signed.....  
Student Embalmer

Licensed Embalmer No. 776

P. O. Address. *Rector, Ark*

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.

*Handwritten notes and signatures at the bottom of the page.*