

FILED NOV 4 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34742**

**BIRTH NO.** \_\_\_\_\_ **REG. DIST. NO.** 291 **PRIMARY REG. DIST. NO.** 4433 **Registrar's No.** 84

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).	
a. COUNTY <b>Putnam</b>		a. STATE <b>Mo.</b> b. COUNTY <b>Putnam</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Unionville</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Unionville</b>	
c. LENGTH OF STAY (In this place) <b>80 yrs</b>		d. STREET ADDRESS (If rural, give location) <b>U. S.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Monroe Hospital</b>			
<b>3. NAME OF DECEASED</b>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
a. (First) <b>Marion</b>		b. (Middle) <b>-</b> c. (Last) <b>Fullhart</b>	
(Type or Print)		<b>Oct. 5 1949</b>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify)	<b>8. DATE OF BIRTH</b>
<b>M</b>	<b>W</b>	<b>M</b>	<b>Nov. 8, 1860</b>
<b>9. AGE</b> (In years last birthday) <b>88</b>		<b>IF UNDER 1 YEAR</b> Months <b>10</b> Days <b>27</b>	<b>IF UNDER 22 YRS.</b> Hours <b>-</b> Min. <b>-</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>Putnam Co., Mo.</b>
<b>13a. FATHER'S NAME</b> <b>Joel Fullhart</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Nancy Melborn</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Ophelia Fullhart</b>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Ophelia Fullhart, Cincinnati, Io.</b>
<b>18. CAUSE OF DEATH</b> 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.		<b>MEDICAL CERTIFICATION</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypostatic pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
ANTECEDENT CAUSES		DUE TO (b) <b>Senile debility</b>	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <u>Sept 15, 1949</u>, to <u>Oct 5, 1949</u>, that I last saw the deceased alive on <u>Oct 5, 1949</u>, and that death occurred at <u>3 p.</u> m., from the causes and on the date stated above.</b>			
<b>23a. SIGNATURE</b> <b>Chas L Judd</b> (Degree or title) <b>D.O.M.</b>		<b>23b. ADDRESS</b> <b>Unionville Mo</b>	<b>23c. DATE SIGNED</b> <b>10-6-49</b>
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>B</b>	<b>24b. DATE</b> <b>10-7-49</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Unionville</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>Unionville, Mo.</b>
<b>DATE REC'D BY LOCAL REG.</b> <b>10-28-49</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Marvell Durbin</b>	<b>GENERAL DIRECTOR'S SIGNATURE</b> <b>W. H. ...</b> <b>ADDRESS</b> <b>Unionville, Mo.</b>	

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

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RECEIVED

NOV 2 1949

District Health Officer No. \_\_\_\_\_

District File Number 11-49-  
NOV 2 1949

Date Filed \_\_\_\_\_

**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

*Murl E. Husted*  
3304

Licensed Embalmer No. \_\_\_\_\_

P. O. Address

*Amoxville, MD*

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.