

FILED AUG 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22802

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>879</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>73 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>		<u>0117</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>840 North 25th Street</u>				d. STREET ADDRESS (If rural, give location) <u>840 North 25th Street</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Perry</u>		b. (Middle) <u>P.</u>		c. (Last) <u>Fulkerson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 31, 1950</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Sept. 16, 1872</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>M.D.</u>		11. BIRTHPLACE (State or foreign country) <u>Andrew County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Peter P. Fulkerson</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Farmer</u>		14. NAME OF HUSBAND OR WIFE <u>Kate H. V. Fulkerson</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>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Kate Fulkerson, 840 North 25 St.</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac decompensation</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostatism</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u> <u>1 year</u>	
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) (Min.)		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>Feb</u> 19 <u>48</u> , to <u>July 31, 1950</u> , that I last saw the deceased alive on <u>July 31, 1950</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>William C. McDonald, M.D.</u>				23b. ADDRESS <u>301 N. 8th St.</u>		23c. DATE SIGNED <u>2 Aug 50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/2/1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Mora</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Aug 7, 1950</u>		REGISTRAR'S SIGNATURE <u>H. G. Jenkins</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter Bowman General Home - St. Joseph, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

SEP 2 1950

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 *William Spelding*

Licensed Embalmer No. *4535*

P. O. Address *795 10th St, St. Joseph, 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.