

FILED AUG 4 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23031**
2835

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL HOSPITAL #2		d. STREET ADDRESS (If rural, give location) 1100 1/2 Independence Avenue	

3. NAME OF DECEASED (Type or Print) a. (First) AARON b. (Middle) WILLIAM c. (Last) FULLER			4. DATE OF DEATH (Month) (Day) (Year) JUNE 19 1951		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH APRIL 8 1883	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) COLUMBIA, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME RICHARD FULLER	13b. MOTHER'S MAIDEN NAME CHARLOTTE	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME MARIE CALDWELL
		ADDRESS 556 Harrison Street

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, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARDIAC INSUFFICIENCY		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) RHEUMATIC HEART DISEASE WITH DECOMPENSATION		
	DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS POSSIBLE PULMONARY TUBERCULOSIS, POSSIBLE MALIGNANCY WITH RT HYDRO PNEUMOTHORAX		

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) (Minute)	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 6-13, 1951 to 6-19, 1951 that I last saw the deceased alive on 6-19, 1951, and that death occurred at 7:45A m., from the causes and on the date stated above.

23a. SIGNATURE OF REGISTRAR Frank Ellis (Degree or title) MD	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 6-19-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Ante-mortem	24b. DATE 7-5-1951	24c. NAME OF CEMETERY OR CREMATORY K. C. Astleathic
24d. LOCATION (City, town, or county) (State) Kansas City, MO		

DATE REC'D BY LOCAL REG. 7-5-51	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE B. Brady - B. Brady	ADDRESS 1718 S. Brady Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BY

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed

C. H. Coontz

Signed.....

Student Embalmer

Licensed Embalmer No. *1271*

P. O. Address *Ferman Cr. 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.