

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **17912**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **187**

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Columbia</b> )		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>Columbia</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Noyes Hospital</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
STREET ADDRESS <b>307 Duncan St.</b>		(If rural, give location) <b>0105 2</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>ALBERT</b>	b. (Middle) <b>TURNER</b>	c. (Last) <b>FULKERSON</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 1, 1954</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 14, 1894</b>	9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farm Foreman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U. of Mo. Soils Dept.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Boone County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Bloomfield Fulkerson</b>	13b. MOTHER'S MAIDEN NAME <b>Eliza Turner</b>	14. NAME OF HUSBAND OR WIFE <b>Lottie May Chandler</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. A.T. Fulkerson, Columbia, Mo.</b>	ADDRESS _____
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart Disease</b>		<b>unknown</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis generalized</b>		<b>unknown</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Peritonitis secondary to diverticulitis of colon</b>		<b>about 3 days</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4200</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **Dec. 27, 1951**, to **July 1, 1954**, that I last saw the deceased alive on **June 30, 1954**, and that death occurred at **6:55 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Charles M. Fawke, M.D.</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>Columbia, Missouri</b>	23c. DATE SIGNED <b>7-2-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>July 3, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Columbia, Missouri.</b>
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DATE REC'D BY LOCAL REG. <b>July 3, 1954</b>	REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Parer Funeral Service, Columbia, Mo.</b>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....  
Signature of Student Embalmer

Signed *M. S. Whiteside*

Licensed Embalmer No. *38*

P. O. Address *Calum*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.