

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32814**

FILED OCT 24 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 900

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Mt Vernon</u>	
c. LENGTH OF STAY (in this place) <u>18 days</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St John's Hospital</u>			
e. STREET ADDRESS (If rural, give location) <u>112 West Clay</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Hobart</u> b. (Middle) <u>S</u> c. (Last) <u>FULTON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 15 1955</u>		
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5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July-23-1896</u>		9. AGE (In years last birthday) <u>59</u>		If UNDER 1 YEAR: Months _____ Days _____		If UNDER 2 HRS: Hours _____ Min. _____	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Ozark County Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
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13a. FATHER'S NAME <u>William I Fulton</u>		13b. MOTHER'S MAIDEN NAME <u>Etta Spradling</u>		14. NAME OF HUSBAND OR WIFE <u>Morothy Keene Fulton</u>	
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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)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Morothy Fulton</u> ADDRESS <u>Mt Vernon Mo</u>	
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Thrombosis of undetermined cerebral vessels</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>HEART DISEASE AND ANEMOSELEMIOSIS, GENERAL.</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>443X</u>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		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 Apr. 25, '54, 19, to OCT. 15, 1955, that I last saw the deceased alive on OCT. 15, 1955, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Shelton C. ...</u> (Degree or title)		23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>10/19/55</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 17-1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Mt Vernon Mo</u>	
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DATE REC'D BY LOCAL REG. <u>10-21-55</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mat L. Fossett</u> ADDRESS <u>Mt Vernon Mo</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 6 1961

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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 *Max L. Farnell*.....

Licensed Embalmer No. *425*.....

P. O. Address *M. L. Farnell*.....

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.