

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

388535

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2471

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kirkwood 46930</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hosp.</u>		Length of stay in lb <u>D.O.A.</u>	d. STREET (If outside, give location) ADDRESS <u>327 Greenleaf Dr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>JAMES ROY FULLERTON</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>5</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1894</u>		9. AGE (In years last birthday) <u>63</u> IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. to Gen. Purch. Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. Pac. R.R.</u>		11. BIRTHPLACE (City and state or country) <u>Sedalia, Mo.</u>	
13. FATHER'S NAME <u>James P. Fullerton</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
14. MOTHER'S MAIDEN NAME <u>Belle Leftwich</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes World War One</u>		
16. SOCIAL SECURITY NO. <u>702-16-0478</u>			17. INFORMANT Address <u>Mrs. Opal Fullerton, 327 Greenleaf Dr.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4200</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>September 27</u> to <u>Oct 5, '57</u> and last saw her/him alive on <u>Oct 5, '57</u> Death occurred at <u>5:15 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Clement J. Sullivan, M.D.</u> (Degree or title)		22b. ADDRESS <u>No. 702, Emory Hosp. Bldg.</u>		22c. DATE SIGNED <u>10-7-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/8/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	
		23d. LOCATION (City/town, or county) <u>Kirkwood 22, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Pfitzinger Mortuary, Kirkwood, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>10-17-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Dornke, M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

Health & Welfare Public Health Service

S. 300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Minimum information in the specific manner required by 193.140 MoKS 1947.

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 *Ben E. [Signature]*

Licensed Embalmer No. *36*

P. O. Address *[Signature]*

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.