

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026657

FILED VS AUG 11 1959

2 7101

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION INCARNATE WORD Hosp.		d. STREET ADDRESS (If outside, give location) 4728 MICHIGAN	

3. NAME OF DECEASED (Type or print) First CORA Middle B. Last FULLER	4. DATE OF DEATH Month JULY Day 30 Year 1959
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH AUG. 19 1877	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIDOW	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) TENNESSEE	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME JOHN H. BARHAM	13b. MOTHER'S MAIDEN NAME GEORGIA TODD	14. NAME OF HUSBAND OR WIFE (DECD) JAMES R. FULLER
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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. NONE	17. INFORMANT GEORGE R. FULLER Address 735 DOVER PL
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vessel thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 days
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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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
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21. I attended the deceased from **7/28** to **7/30** and last saw her him alive on **7/30**
Death occurred at _____ **7 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ralph Bergon (Degree or title)	22b. ADDRESS 3203S Grand	22c. DATE SIGNED 7/31/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE AUG. 1 1959	23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PK	23d. LOCATION (City, town, or county) (State) ST. LOUIS Mo
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24. FUNERAL DIRECTOR Thomas Kutas 2906 Gravis ADDRESS	25. DATE RECD. BY LOCAL REG. JUL 31 1959	26. REGISTRAR'S SIGNATURE Loed Smith, M.D.
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BY AFFIDAVIT OF MEDICAL CERTIFICATION DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Donna C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 S

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.