

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028226

FILED VS AUG 24 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 835

STATE FILE NUMBER

| | | | | | | | | |
|--|---|---|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan | | | | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph, Missouri | | Length of stay in 1b 39 years | | c. CITY OR TOWN St. Joseph, Missouri | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 2705 Lafayette Wyatt Park Nursing Home | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (if outside, give location) 2723 Patee | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle ISAAC Last FULLER | | | | 4. DATE OF DEATH Month August Day 12 Year 1959 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH Mar 18, 1875 | 9. AGE (last birthday) 84 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Darlington, Missouri | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Eliza Fuller | | | 13b. MOTHER'S MAIDEN NAME Maria Chowning | | | 14. NAME OF HUSBAND OR WIFE Emma Viola Fuller | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 491-10-6229 | | 17. INFORMANT Address Mrs. Harold Boore, 1608 So 12, St. Joseph, | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive-cardiovascular disease & cerebrovascular accident (Haemorrhage) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7-23-56 | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) Arteriosclerosis general | | DUE TO (c) Congestive Failure | | | INTERVAL BETWEEN ONSET AND DEATH 1WK | |
| 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 type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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.) | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | 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 7-23-56 to 8-12-59 and last saw him alive on 7-16-59 Death occurred at 8-12-59 8:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Wm B Roach M.D. | | | | 22b. ADDRESS 316 North St Joseph, Mo | | | 22c. DATE SIGNED 8-12-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE 8/14/1959 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | 23d. LOCATION (City, town, or county) St. Joseph, Mo. | | (State) | |
| 24. FUNERAL DIRECTOR Heaton Burman | | | ADDRESS St. Joseph, Missouri | | 25. DATE RECD. BY LOCAL REG. Aug. 17, 1959 | 26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 5th St

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.