

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032346

FILED VS SEP 25 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4454 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>50 yrs</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5733 Charlotte</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>M.</b> Last <b>FULLER</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>12</b> Year <b>1959</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 14, 1890</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photo Engraver</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Graphic Arts Engraving Self Co.</b>		11. BIRTHPLACE (City and state or country) <b>Marrion, Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13a. FATHER'S NAME <b>Issac H. Fuller</b>			13b. MOTHER'S MAIDEN NAME <b>Amanda E. Black</b>		14. NAME OF HUSBAND OR WIFE <b>Edna M. Fuller</b>				
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. <b>486-01-6931</b>	17. INFORMANT Address <b>Edna M. Fuller, 5733 Charlotte</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <b>Coronary occlusion</b>							<b>17 days</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 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 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 <b>Aug 25 59</b> to <b>sept 11-59</b> and last saw <sup>per</sup> him <sup>live</sup> on <b>sept 10 59</b> Death occurred at <b>2:30 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Wm R. Jackson M.D.</b>				22b. ADDRESS <b>1107 Bryant Blvd</b>				22c. DATE SIGNED <b>9/14/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-14-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cemetery</b>		23d. LOCATION (City, town, or county) <b>Kansas City, Mo.</b>				
24. FUNERAL DIRECTOR <b>Melody-McGilley-Eylar Funeral Home</b>				25. DATE RECD. BY LOCAL REG. <b>9-14-59</b>		26. REGISTRAR'S SIGNATURE <b>New Minshall</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Wm R. Jackson

Woodland-Linwood

(Licensed Embalmer's Statement on Reverse Side)

10. 11. 1  
Page 10  
11. 30

**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 E. L. Gibson

Licensed Embalmer No. 4137

P. O. Address Exelion Springs

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.