

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**60-003409**

FILED VS JAN 29 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 270 STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Massachusetts</u> b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b _____	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cardinal Glennon Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1817 N. Market St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Dean</u> Last <u>Fulliam</u>			4. DATE OF DEATH Month <u>January</u> Day <u>2nd</u> Year <u>1960.</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2, 1900</u>	9. AGE (last birthday) <u>11 hours</u>	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Fulliam</u>		13b. MOTHER'S MAIDEN NAME <u>Carolyn Lockett</u>		14. NAME OF HUSBAND OR WIFE _____		
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. <u>none</u>	17. INFORMANT <u>Carolyn Fulliam</u> Address <u>1817 N. Market</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>otolubria neonatorum</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>762.5</u>					INTERVAL BETWEEN ONSET AND DEATH _____	
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 checked="" type="checkbox"/> NO <input 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 _____	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>1-2-60</u> to <u>1-3-60</u> and last saw her/him alive on <u>3:45 AM 1-3-60</u> Death occurred at <u>3:30 AM 1-3-60</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>John D. Buchanan M.D.</u>			22b. ADDRESS <u>1465 SE Grand</u>		22c. DATE SIGNED <u>1/4/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Reinterment</u>	23b. DATE <u>Jan. 4, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lick Creek Cem.</u>	23d. LOCATION (City, town, or county) <u>Cuba Mo.</u>			
24. FUNERAL DIRECTOR <u>Buell Campbell Mortuary</u> ADDRESS <u>5765 Highway</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 5 1960</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>			

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 Not Embalmed, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. Louis

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.