

FEDERAL BUREAU OF INVESTIGATION FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-016823

FILED VS APR 18 1960

2 3827

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		d. STREET ADDRESS (If outside, give location) 5704 Walsh	
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Edward Fulstone		4. DATE OF DEATH Month Day Year 4/3/60	
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/15/1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Stix-Baer-Fuller	11. BIRTHPLACE (City and state or country) St. Louis Mo
13a. FATHER'S NAME Robert Fulstone		13b. MOTHER'S MAIDEN NAME Not Known	14. NAME OF HUSBAND OR WIFE Adele Fulstone
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. ---	17. INFORMANT Address Adele Fulstone, 5704 Walsh
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION			INTERVAL BETWEEN ONSET AND DEATH 3 wks.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIO SCLEROTIC HEART DISEASE			2 Months
DUE TO (c) 420.0			
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 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 3/11/60 to 4/3/60 and last saw ^{her} _{him} alive on 4/2/60 Death occurred at 4:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) George A. Hamon MD		22b. ADDRESS 5500 Chippewa	22c. DATE SIGNED 4/4/60
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 4/6/60	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, County Mo.
24. FUNERAL DIRECTOR ADDRESS John L. Ziegenhein & Sons, 7027 Gravois		25. DATE RECD. BY LOCAL REG. APR 6 1960	26. REGISTRAR'S SIGNATURE Keat Smith M.D.

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 G. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Grand

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.