

1939 OCT 12 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32015
Do not use this space.

1. PLACE OF DEATH 3

(a) County Callaway Registration District No. 104

(b) Township Fulton Primary Registration District No. 3008 Registered No. 248

(c) City Fulton (d) Street No. State Hosp. #1 St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Washington

(a) Residence, No. Fayette Mo. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>60 years</u>			

8. Grade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc. None

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howard County

FATHER

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) State Hosp #1 - record Fulton Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hospital Grounds DATE Sept 9, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) G. P. Pharoah 302 Market St Fulton Mo

20. FILED Sept 9, 1939 R. N. Crews Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/8, 1939

22. I HEREBY CERTIFY, That I attended deceased from 9/7, 1939 to 9/8, 1939

I last saw him alive on 9/7, 1939 Death is said to have occurred on the date stated above, at 12:15 A.M.

The principal cause of death and related causes of importance were as follows:

Cardiac Decomposition
Terminal Embolism
Cerebral Edema

Other contributory causes of importance: 95 to 100

Name of operation _____ Date of _____

What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (Violence), fill in also the following:

Accident, suicide, or homicide? No Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) Dr. J. Wood, M. D.

(Address) State Hosp #1 Fulton Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X16605

STATEMENT BY LICENSED EMBALMER

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.