

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **19821**

Registration District No. **996**

Primary Registration District No. **6200**

Registrar's No. **17**

1. PLACE OF DEATH:

(a) County Webster
 (b) City or town rural - High Prairie township
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location) **2**
 (d) Length of stay: In hospital or institution X (Specify whether
 In this community life years, months or days)

8. (a) PRINT FULL NAME Mildred Luella Fullington

3. (b) If veteran, name war X 5. (c) Social Security No. X

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased June 6 - 1920
 (Month) (Day) (Year)

8. AGE: Years 19 Months 9 Days 13 If less than one day X hr. X min.

9. Birthplace Webster County, Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business X

12. Name D.A. Fullington

13. Birthplace Webster County, Missouri
 (City, town, or county) (State or foreign country)

14. Maiden name Millie Alexander

15. Birthplace Webster County, Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature H.A. Fullington

(b) Address Marshfield Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 21-1940
 (Month) (Day) (Year)

(c) Place: burial or cremation Black Oak

18. (a) Signature of funeral director Rex King

(b) Address Marshfield Mo

19. (a) Apr-15-40 (Date received local registrar) (b) Chapman Thelma (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster
 (c) City or town rural - High Prairie township
 (If outside city or town limits, write "RURAL")
 (d) Street No. X (If rural, give location)
 (e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
 year 1940 hour 6 minute 50 P. M.

21. I hereby certify that I attended the deceased from June 19, 1939 to March 19, 1940
 that I last saw her alive on March 14, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, Pulmonary Duration 10mo.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations No

Of autopsy No

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
824 (Specify type of place) While at work? (e) Means of injury _____

23. Signature C.P. Macdonnell (M. D. or other) MD
 Address Marshfield, Ma Date signed 3/20/40

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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.

RECEIVED

District Health Officer No. 6,

District File Number 640-1443

Date Filed MAY 21 1940

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 Her Laine

Licensed Embalmer No. 3312

P. O. Address Manchester, Mo

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.