

FILED AUG 14 1940

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

24779
Do not use this space.

1. PLACE OF DEATH ³⁰
 (a) County Lullaway Registration District No. 104
 (b) Township Fulton Primary Registration District No. 3008 Registered No. 192
 (c) City Fulton (d) Street No. State Hosp #1 St. Mo.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 30 yrs. 5 mos. 7 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL-NAME Richard Fognini
 (a) Residence, No. _____ St. Gasper County Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) ?

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 (years)

8. Trade, 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. _____

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) 9 2

13. NAME 9 3

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9 2

15. MAIDEN NAME ?

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

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

18. BURIAL, CREMATION, OR REMOVAL PLACE Columbia ma Mo 8-1 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. G. Roberts Columbia Mo

20. FILED Aug 1 1940 R. N. Crews Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-30-40

22. I HEREBY CERTIFY, That I attended deceased from June 30 1938 to July 30 1940
 I last saw him alive on 7/30/40. Death is said to have occurred on the date stated above, at 9:40p m.
 The principal cause of death and related causes of importance were as follows:
Arteriosclerosis
Epileptic Discharges (Clouded Hx)
 Date of onset 45

Other contributory causes of importance:
Arteriosclerosis

Name of operation _____ Date of _____
 What test confirmed diagnosis? Phy Ex Was there an autopsy? _____

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) Geo. F. 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.

Social Security # none

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.