

5-17-39  
I X21492

FILED SEP 16 1940

State File No.

691

Registration District No. 318

Primary Registration District No. 5440

Registrar's No.

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Medical Center for Federal Prisoners  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 mos. & 17 days  
In this community 8 mos. & 17 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State California (b) County Placer  
(c) City or town Colfax  
(If outside city or town limits, write "RURAL")  
(d) Street No. Unknown  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME FULTON, C. W. 435

3. (b) If veteran, name war World War 3. (c) Social Security No. Unknown

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

6. (b) Name of husband or wife Thelma McGowan 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased (Month) 12 (Day) 14 (Year) 1871

8. AGE: Years 68 Months 8 Days 8 If less than one day hr. min.

9. Birthplace Colfax California  
(City, town, or county) (State or foreign country)

10. Usual occupation Doctor & Druggist

11. Industry or business Unknown

12. Name Robert McGowan

13. Birthplace Unknown Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Taussiz

15. Birthplace Unknown Wisconsin  
(City, town, or county) (State or foreign country)

16. (a) Informant Deceased

(b) Address

17. (a) Burial (b) Date thereof Aug 26 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Center

18. (a) Signature of funeral director Alvin Johnson

(b) Address Springfield Mo

19. (a) Aug 26 1940 (b) W. C. Handley  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22nd, year 1940 hour 9:00 minute 25 P.M.

21. I hereby certify that I attended the deceased from Dec. 5th, 1939, 19  , to Aug. 22nd, 1940

that I last saw him alive on Aug. 22nd, 1940, 19  ; and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, Pulmonary, Acute Pneumonic 1766

Due to

Due to

Other conditions

Major findings: Of operations

Of autopsy Yes

Diagnosis verified by Clinical

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? 984

(Specify type of injury) While at work No (Specify type of means of injury)

23. Signature L. M. ROGERS (M. D. or other) N.D.  
Address Clinical Director MCFP Date signed

Duration since 4/10/40  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**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.....

*C. C. George*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Lewis J. Schaff*

..... Licensed Embalmer No. *3802*

..... P. O. Address. *Springfield, Ill.*

**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.**

X