

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29603**

Registration District No. **784**

Primary Registration District No. **200**

Registrar's No. **1629**

1. PLACE OF DEATH:

(a) County: **Osage**
 (b) City or town: **Shillock Park Mo**
 (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 **2**
 In this community **two yrs.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Missouri** (b) County: **Sh. Lewis**
 (c) City or town: **Shillock Park Mo**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **10 Boyd**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME

BEATRICE Fuller Hol

3. (b) If veteran, name war.

3. (c) Social Security No. **None**

4. Sex: **Female** 5. Color or race: **Negro** 6. (a) Single, widowed, married, divorced: **Married**
 6. (b) Name of husband or wife: **Charles Fuller** 6. (c) Age of husband or wife if alive: **40** years
 7. Birth date of deceased: **July 21 1909**
 (Month) (Day) (Year)

8. AGE: Years **31** Months **1** Days **3** If less than one day hr. min.

9. Birthplace: **Ark.** (City, town, or county) (State or foreign country)

10. Usual occupation: **House Work**

11. Industry or business: **at Home**

12. Name: **Sperner Sargent**
 13. Birthplace: **Mississippi**
 (City, town, or county) (State or foreign country)
 14. Maiden name: **Josie R. Sargent**
 15. Birthplace: **Ark**
 (City, town, or county) (State or foreign country)

16. (a) Informant: **Josie Sargent**
 (b) Address: **40 Carson + Boyd St**

17. (a) **Burial** (b) Date thereof: **8-28-40**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation: **Washington Park Cemetery**

18. (a) Signature of funeral director: **Atkins Bro**
 (b) Address: **3446 Finney Ave**
 19. (a) **AUG 27 1940** (b) **DR. M. J. ...**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **24**
 year **1940** hour **7** minute **150.** M.

21. I hereby certify that I attended the deceased from **6-28-** 1940 to **Aug 20-** 1940
 that I last saw her alive on **Aug 20** and that death occurred on the date and hour stated above.

Immediate cause of death: **Pulmonary Bronchitis** Duration: **1 month**

Due to: **1060**

Due to:

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations:

Of autopsy:

Duration
1 month

PHYSICIAN

Underline the cause to which death should be charged statistically:

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature: **Dr. M. J. ...** (M. D. or other)
 Date: **8-26-40**

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

0-39
39
21492

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

Louis V. Atkins

Licensed Embalmer No.

2842

P. O. Address

3644 Fin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

190A