

DEPARTMENT OF COMMERCE **FILED JUN 10 1941** MISSOURI STATE BOARD OF HEALTH  
BUREAU OF THE CENSUS **STANDARD CERTIFICATE OF DEATH**

State File No. **17440**

Registration District No. **399** Primary Registration District No. **1002** Registrar's No. **2102**

1. PLACE OF DEATH:  
(a) County **Jackson**  
(b) City or town **Kansas City**  
(c) Name of hospital or institution: **St. Joseph Hospital**  
(d) Length of stay: In hospital or institution **Support given**  
In this community **write**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
Street No. **3420 E. 10th Street**  
(e) If foreign born, how long in U. S. A.? **0** years.

3. (a) PRINT FULL NAME **Mrs. SARAH E. FULK**

3. (b) If veteran, name war **---** 3. (c) Social Security No. **---**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W**

6. (b) Name of husband or wife **Henry Fulk** 6. (c) Age of husband or wife if alive **---** years

7. Birth date of deceased **Sept. 1, 1872**

8. AGE: Years **68** Months **8** Days **28** If less than one day **---** hr. **---** min.

9. Birthplace **unknown G**

10. Usual occupation **housewife**

11. Industry or business **at home**

12. Name **unknown**

13. Birthplace **unknown G**

14. Maiden name **unknown**

15. Birthplace **unknown G**

16. (a) Informant **Hospital Records**

(b) Address **St. Josephs Hospital, E.C. 116.**

17. (a) **Removal** (b) Date thereof **May 29, 1941**

(c) Place: burial or cremation **Leavenworth, Kansas.**

18. (a) Signature of funeral director **J.C. Doy's Undertaking Co.**

(b) Address **Leavenworth, Kansas.**

19. (a) **May 29 1941** (b) **M. M. Brown**

(Date received at local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **May** day **29** year **1941** hour **3** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **---**, 19**---**, to **---**, 19**---**; that I last saw him **---** alive on **---**, 19**---**; and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Pulmonary Edema**

Due to **Chronic Hypertensive myocarditis**

Due to **---**

Other conditions **---**

Major findings: Of operations **---**

Of autopsy **Ac. Pulm. Edema  
Chronic Hypertensive Myocarditis**

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? **---**

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **---**

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

23. Signature **W. H. Halliday** (M. D. or other) **---**

Address **St. Joseph Hosp.** Date signed **5/29/41**

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

---

---

**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..... *Arthur F. McClure* .....

Licensed Embalmer No. *3939* .....

P. O. Address..... *Leavenworth, Kans* .....

**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, fact should be so stated above.**