G. No. 2
M—5-42
5-17-39
P I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 1 1942

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25843

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7112

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 96

(a) State Missouri (b) County

(c) City or town St. Louis NR
(If outside city or town limits, write "RURAL")

(d) Street No. 6648 Washington
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Peter (Percival) Hunter Fullinwider

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Annis Fullinwider

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

7. Birth date of deceased March (Month) 14 (Day) 1870 (Year)

8. AGE:

Years	Months	Days	If less than one day
72	5	10	hr. min.

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

10. Usual occupation Claim Freight Adjuster

11. Industry or business Missouri Pacific Railway

FATHER
12. Name Jacob Fullinwider
13. Birthplace (City, town, or county) Texas (State or foreign country)

MOTHER
14. Maiden name Francis Arnold
15. Birthplace (City, town, or county) Conn (State or foreign country)

16. (a) Informant Annis Fullinwider
(b) Address 6648 Washington

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/25/42 (Month) (Day) (Year)
(c) Place: burial or cremation Sherman, Texas

18. (a) Signature of funeral director Edith E. Ambruster
(b) Address 4234 Manchester

19. (a) AUG 25 1942 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24
year 1942 hour 5 minute 15 P.M.

21. I hereby certify that I attended the deceased from August 20, 1942, to August 24, 1942, that I last saw him alive on August 24, 1942, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	
Cystitis - Catarrhal	
Due to: Arteriosclerosis	
Due to: 83 a	
Other conditions (Include pregnancy within 3 months of death): 83 a	
Major findings: Of operations	
Of autopsy	

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

23. Signature [signature] (M. D. or other) Med
Address 1755 Soldiers Date signed 8-25-42

844 (Licensed Embalmer's Statement on Reverse Side)

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 Florenz Eynck

Licensed Embalmer No. 1284

P. O. Address St Louis 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, fact should be so stated above.

S. No. 2B
00—4-25-41
I X27852

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____ Primary Registration District No. _____ Registrar's No. [redacted]2

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

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 6648 Washington
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Peter (Percival) Hunter Fullmarker

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

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

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 72 Months 5 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 7/28/42 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24
year 1942 hour _____ minute _____ M.

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

	Duration
Immediate cause of death _____	
Due to _____	
Due to _____	
Other conditions (Include pregnancy within 3 months of death) _____	
Major findings: Of operations _____	
Of autopsy _____	

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

S-25843