. S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18719

FILED JUN 21 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5216

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: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days (Specify whether
In this community About 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 1420 Whittier St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country No

3. (a) PRINT FULL NAME Jake Fullbright

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race Colored

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

6. (b) Name of husband or wife Aline Fullbright

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased March (Month) 1 (Day) 1865 (Year)

8. AGE: Years 80 Months 3 Days 7 If less than one day hr. min.

9. Birthplace Baxton Springs, Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Laundry Man

11. Industry or business None

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

MOTHER
14. Maiden name Susie Fullbright
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Aline Fullbright
(b) Address 1420A Whittier

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14, '45 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson Cem.

18. (a) Signature of funeral director C. J. Noshal
(b) Address 111 N. 13 No. St. - E. St. Louis, Ill.

19. (a) JUN 13 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8, year 1945 hour 4 minute 05 P.M.

21. I hereby certify that I attended the deceased from May 21, 1945 to June 8, 1945 that I last saw him alive on June 8, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Arteriosclerotic Hypertensive heart disease with congestive failure	Unk.
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 B. F. Murphy (M. D. or other)
Address 2601 Whittier Date signed 6/9/45

(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 C. J. Nook

Licensed Embalmer No. 2432

P. O. Address 1114 13th St.

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.