

S. No. 2  
DM-2-43  
7-5-17-39  
P-1 X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22931

State File No. \_\_\_\_\_

FILED AUG 4 1945

Registration District No. 189

Primary Registration District No. 1002

Registrar's No. 3067

1. PLACE OF DEATH:  
 (a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
K. C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 4600 Genessee  
(If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Grace Fulton  
 3. (b) If veteran, name war none  
 3. (c) Social Security No. none

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July day 21  
 year 1945 hour 11 minute A. M.

4. Sex Female 5. Color or race white  
 6. (a) Single, widowed, married, divorced, widowed  
 6. (b) Name of husband or wife Herman L. Fulton  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from July 18, 1945 to July 21, 1945  
 that I last saw her alive on July 21, 1945  
 and that death occurred on the date and hour stated above.

7. Birth date of deceased: Dec. 18 1875  
(Month) (Day) (Year)

Immediate cause of death: Cachexia  
 Duration \_\_\_\_\_

| 8. AGE: | Years     | Months   | Days     | If less than one day |
|---------|-----------|----------|----------|----------------------|
|         | <u>69</u> | <u>7</u> | <u>3</u> | hr. _____ min. _____ |

Due to Terminal Carcinoma site not determined

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

Due to \_\_\_\_\_

10. Usual occupation housewife

Other conditions (include pregnancy within 3 months of death) 552

11. Industry or business at home

Major findings: Of operations \_\_\_\_\_

12. Name Francis A. Robian

Of autopsy None

13. Birthplace Brussell Belgium no record  
(City, town, or county) (State or foreign country)

14. Maiden name Louise Finken

15. Birthplace Germany no record  
(City, town, or county) (State or foreign country)

16. (a) Informant Charles L. Fulton  
 (b) Address 4620 Mercier

17. (a) burial (b) Date thereof 7/23/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Quindaro Cem. K.C.

18. (a) Signature of funeral director Gates Funeral Home  
 (b) Address Kansas City, Kans.

19. (a) 7-23-45 (b) Stearline Holme  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

23. Signature Cliff A. Salyer (M. D. or other) MD  
 Address Med. Dir. Gen'l Hosp. Date signed 7-21-45

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *W. J. Ward*

Licensed Embalmer No. 3991

P. O. Address 309 E 67<sup>th</sup>

**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.

*K. C. M.*