

S. No. 2
DM-2-43
v. 5-17-39
G-1 X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37069**

FILED DEC 12 1945
Registration District No. **707**

Primary Registration District No. **3019**

Registrar's No. **39**

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Kennett, 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)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 30 yr
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dunklin

(c) City or town Kennett, Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 905 E. 4th St
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Amanda Francis Fuller

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 13 - 1945
year 4th hour _____ minute 10 P. M.

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

6. (b) Name of husband or wife W. H. Fuller 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased: _____ (Month) (Day) (Year) 1869

21. I hereby certify that I attended the deceased from Nov 8, 1945, to 11-13, 1945, that I last saw her alive on Nov-12, 1945, and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>76</u>	<u>1</u>	<u>6</u>	hr. _____ min. _____

Immediate cause of death Cerebral apoplexy

Duration 5d

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

Due to _____

Due to _____

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

10. Usual occupation Housewife

11. Industry or business _____

Major findings: _____

Of operations _____

Of autopsy _____

MOTHER { 12. Name John Joseph Long

13. Birthplace Mo (City, town, or county) (State or foreign country)

14. Maiden name Dora Knaw

15. Birthplace Dont Knaw (City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant W. H. Fuller

(b) Address Kennett, Mo

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence _____

17. (a) Burial (Burial, cremation or removal) (b) Date thereof 11-15-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Ridge

(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? _____

18. (a) Signature of funeral director W. H. Long

(b) Address Rectors Ark

19. (a) 11-23-1945 (Date received local registrar) (b) Carl Hubbard (Registrar's signature)

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

23. Signature Paul Ballou (M. D. or other) 11-40

Address Kennett Mo Date signed 11-15-45

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

RECEIVED

District Health Office No. 2,

District File Number 1245-3359

Date Filed 12/6/45

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 John R. Casner

Licensed Embalmer No. 2912

P. O. Address Rector, Ark

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.