

S. No. 2
-12-45
5-17-39
P I X47079

FILED JAN 27 1947

Registration District No. _____ Primary Registration District No. **1002**

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

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 day**
(Specify whether years, months or days)

In this community **unknown**

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. **534 main st**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Ross Fuller**

3. (b) If veteran name war **Donatima Donatima**

3. (c) Social Security No. **Donatima**

4. Sex **Male** 5. Color or race **white**

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

6. (b) Name of husband or wife **unknown**

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

7. Birth date of deceased **March 4 1884**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **16** year **1947** hour **10** minute **P.** M.

21. I hereby certify that I attended the deceased from **Jan. 15 1947** to **Jan. 16 1947** that I last saw him alive on **Jan. 16 1947** and that death occurred on the date and hour stated above.

8. AGE: Years **62** Months **10** Days **12** If less than one day hr. min.

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

10. Usual occupation **none**

11. Industry or business _____

12. Name **Charles Fuller**

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

14. Maiden name **Frances Wright**

15. Birthplace **Iowa**
(City, town, or county) (State or foreign country)

16. (a) Informant **General Hospital Record**

(b) Address **12 c mo**

17. (a) **Removal** (b) Date thereof **Jan 19 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rock Island Ill.**

18. (a) Signature of funeral director **Parsons Bros**

(b) Address **12 c mo**

19. (a) **1-18-47** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

Immediate cause of death **Coronary infarction**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **940**

Major findings: Of operations _____

Of autopsy **none**

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **Wm W Hart** (M. D. or other) **MA**
Address **Med. Dir. Gen'l Hosp** Date signed **1-17-47**

for Administration of the

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..... *Francis Walton*

Licensed Embalmer No. *2744*

P. O. Address..... *K.C. 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.