S. No. 2
DM—2-43
. 5-17-39
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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. 16382

FILED MAY 7 3 1947

Registration District No. ____ Primary Registration District No. 4480 Registrar's No. 86

1. PLACE OF DEATH:
(a) County: Schuyler
(b) City or town: Greentop
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Vanosdol Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days)
In this community 86 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Schuyler 98
(c) City or town: Greentop 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME: CHARLES WATSON FUGATE
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: widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: April (Month) 23 (Day) 1861 (Year)

8. AGE: Years 86 Months 0 Days 9 If less than one day ____ hr. ____ min.

9. Birthplace: Schuyler County Mo. (City, town, or county) (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business:
MOTHER FATHER
12. Name: Elbert Fugate
13. Birthplace: Virginia (City, town, or county) (State or foreign country)
14. Maiden name: Catherine Hoffert
15. Birthplace: Indiana (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. Isabell Buchanan
(b) Address: Greentop, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/47 (Month) (Day) (Year)
(c) Place: burial or cremation: New Harmony Cemetery
18. (a) Signature of funeral director: Wm. A. West
(b) Address: Queen City, Mo.
19. (a) May 3, 1947 (Date received local registrar) (b) Fred A. J. Drake (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 1 year 1947 hour 9 minute 15 A.M.
21. I hereby certify that I attended the deceased from April 21, 1947 to May 1, 1947 that I last saw him alive on May 1, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of gall bladder

Due to:

Due to:

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

Major findings: Of operations: 5/10

Of autopsy:

Duration

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: 21

23. Signature: [illegible] (M.D. or other) D.O.
Address: Greentop Mo. Date signed 5-7-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 5-47-799
Date Filed MAY - 6 1947

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

Signed Wm M West

Licensed Embalmer No. 2882

P. O. Address Queencity 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.