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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 96 Primary Registration District No. 6290 Registrar's No. 58

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

1. PLACE OF DEATH:

(a) County DALLAS
(b) City or town BUFFALO "RURAL"
(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 LIFE
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DALLAS 30
(c) City or town BUFFALO "RURAL" 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ROSETTA ANN FULLERTON
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MONROE
6. (c) Age of husband or wife if alive years
7. Birth date of deceased JAN. (Month) 12 (Day) 1877 (Year)

8. AGE: Years 70, Months 7, Days 4 If less than one day hr. min.

9. Birthplace DALLAS CO (City, town, or county) MO. (State or foreign country)
10. Usual occupation HOUSEKEEPER
11. Industry or business
FATHER
12. Name JOSEPH CLINE
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name MARTHA
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)
16. (a) Informant T. M. FULLERTON
(b) Address BUFFALO MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-16-47 (Month) (Day) (Year)
(c) Place: burial or cremation MACEDONIA
18. (a) Signature of funeral director L. B. JONES
(b) Address BUFFALO, MO
19. (a) 9-14-47 (Date received local registrar) (b) Mrs. L. B. Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 19
year 1947 hour 7 minute 58 A. M.
21. I hereby certify that I attended the deceased from on Aug 18, 1947, to Aug 19 1947
that I last saw him alive on Aug 19, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion	10 hrs
Due to Arterio Sclerosis & hypertension	DK
Due to	
Other conditions Work & Worry (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy 94A 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?
(Specify type of place)
While at work? (e) Means of injury 0
23. Signature G. C. Plummer (M. D. or other) MD
Address Buffalo MO Date signed 9-9-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
Date 8-42-1088
9-16-47

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 [signature]

Licensed Embalmer No. 2508

P. O. Address Buffalo 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.