No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED APR 21 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12147

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 288

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 31
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. 800 University 6
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME JAMES FRANKLIN FULBRIGHT
3. (b) If veteran, name war unknown
3. (c) Social Security No. unknown
4. Sex M 0
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Maude
6. (c) Age of husband or wife if alive unknown years
7. Birth date of deceased January (Month) 24 (Day) 1877 (Year)

8. AGE: Years 71 Months 2 Days 13 If less than one day ..... hr. ..... min.

9. Birthplace Millersville (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation Attorney
11. Industry or business Law
FATHER
12. Name Peter Fulbright
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9
MOTHER
14. Maiden name Elizabeth Gilliland
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9
16. (a) Informant Maude Fulbright (wife)
(b) Address 800 University
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Apr 7, 1948 (Month) (Day) (Year)
(c) Place: burial or cremation Doniphan, Missouri
18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
(b) Address Springfield, Missouri
19. (a) 4-7-48 (Date received local registrar) (b) W E Handley M D (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 5
year 1948 hour 7 minute 45 P. M.
21. I hereby certify that I attended the deceased from 9-20-47
....., 19....., to 4-5 1948;
that I last saw him alive on 4-5-48, 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death gastric hemorrhage

Due to adenocarcinoma of stomach & generalized metastasis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations adenocarcinoma stomach
Of autopsy 46 B

Duration

PHYSICIAN
Underline the cause of 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 T. Gerrell (M. D. or other)
Address Springfield Mo Date signed 4/6/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Wound

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 Richard E. Watts, Registered Apprentice No. 206, working under my personal supervision.

Signed Jewell E. Windle

Licensed Embalmer No. 2831

P. O. Address Springfield 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.