

FILED MAR 22 1949

STANDARD CERTIFICATE OF DEATH

State File No. **8376**
898

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson ✓	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 21 yrs.		d. STREET ADDRESS (If rural, give location) 1210 Paseo	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Wheatley Providence			

3. NAME OF DECEASED (Type or Print) a. (First) Luther Fulbright b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) February 24, 1949		
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5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Oct. 23, 1902		9. AGE (In years last birthday) 46		IF UNDER 1 YEAR Months Days		IF UNDER 4 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Sheffield Steel				11. BIRTHPLACE (State or foreign country) Dennison, Texas				12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME Parrin Fulbright			13b. MOTHER'S MAIDEN NAME Matelda Stevens			14. NAME OF HUSBAND OR WIFE None		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT'S SIGNATURE OR NAME Bernella Fulbright		ADDRESS Denver, Colo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculosis						INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Syphilis							
		DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **Feb 9**, 19**49**, to **Feb 24**, 19**49**, that I last saw the deceased alive on **Feb 24**, 19**49**, and that death occurred at **9:30** m., from the causes and on the date stated above.

23a. SIGNATURE J. M. Walden (Degree or title) Dr.		23b. ADDRESS 17387 West		23c. DATE SIGNED 2/25/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/26/49		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Dennison, Texas	
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DATE REC'D BY LOCAL REG. 2-26-49		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE Walter Bess		ADDRESS 1729 Lydia	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Waldow

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

J. J. Manlove

Licensed Embalmer No. *3994*

P. O. Address *2503 Highland*

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.