

FILED APR 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14527

State File No. _____

318

1003

3387

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Arkansas b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 22 days	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Warren,		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital,			

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) W. c. (Last) Fullerton			4. DATE OF DEATH (Month) (Day) (Year) April 8 1950		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11/3/1880	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Mfg.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Beloit, Kansas, / /		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Samuel H. Fullerton,	13b. MOTHER'S MAIDEN NAME Lucy Cook,	14. NAME OF HUSBAND OR WIFE Stella B. Fullerton,
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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. 720-14-0872	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. S. B. Fullerton, Warren, Ark.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cor Pulmonale DUE TO (c) Chronic bronchitis and emphysema 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 checked="" 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) 502.0
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?

22. I hereby certify that I attended the deceased from March 17, 1950, to April 8, 1950, that I last saw the deceased alive on April 8, 1950, and that death occurred at 11:50 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank R. Bradley M.D.	23b. ADDRESS Barnes Hospital,	23c. DATE SIGNED April 8-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 4/12/50	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. APR 11 1950	REGISTRAR'S SIGNATURE J. B. Hooster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wagoner Mortuary, 4161 Lindell Blv.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0561 1 1 706

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Robert T. Sargester

Signed.....
Student Embalmer

Licensed Embalmer No. 4290

P. O. Address St Louis, 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.