

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10735**

FILED MAR 26 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2015**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before adjustment). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. CITY OR TOWN <b>4505 Richmond/Heights</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>3 days</b>		e. STREET ADDRESS (If rural, give location) <b>1329 McCutcheon Road</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>MELVIN</b>	b. (Middle) <b>DONNELLY</b>	c. (Last) <b>FULCHER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 25, 1956</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 9, 1884</b>	9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Reporter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Post-Dispatch</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>West Plains, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Thomas M. Fulcher</b>	13b. MOTHER'S MAIDEN NAME <b>Cornelia Mann</b>	14. NAME OF HUSBAND OR WIFE <b>Jane Fulcher</b>
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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) <b>Yes World War I</b>	16. SOCIAL SECURITY NO. <b>489-22-0549</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Jane Fulcher</b>	ADDRESS <b>1329 McCutcheon Rd.</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  <b>10 years</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardiovascular disease</b>		
	DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Residual ulcer, chronic Bronchial asthma</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>443x</b>	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 May, 1954, to present, 19    , that I last saw the deceased alive on Feb 24, 1956, and that death occurred at 12:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE <b>Robert P. Hengeman</b>	(Degree or title) <b>MD</b>	23b. ADDRESS <b>31 North Brentwood Blvd Clayton 5, Mo</b>	23c. DATE SIGNED <b>2-26-56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Feb. 27, 1956</b>	24c. NAME OF CEMETERY <b>Ware's Grove</b>	24d. LOCATION (City, town, or county) (State) <b>Butler, Illinois</b>
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DATE REC'D BY LOCAL REG. <b>FEB 27 1956</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith m.d.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>m.j.B.</b>	ADDRESS <b>Stock Mortuary, 889 S. Brentwood Bl.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

**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.....  
Signature of Student Embalmer

Signed.....  
*Paul A. Kach*

Licensed Embalmer No. 47

P. O. Address *H. H. ...*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.**  
to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.