Health, Welfare Public Service

300
1-56

FILED MAR 25 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11792
STATE FILE NUMBER

Registration District No. 337 Primary Registration District No. 9997 Registrar's No. 27

1. PLACE OF DEATH
a. COUNTY SHELBY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLARENCE MO — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CLARENCE — Length of stay in Hospital 12 YRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY SHELBY
c. CITY OR TOWN CLARENCE — Inside Limits Yes X No ☐
d. STREET ADDRESS CLARENCE MO (If outside, give location) — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First JOHN Middle — Last FULLER
4. DATE OF DEATH Month MARCH Day 18 Year 1957
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH DEC 24 1870
9. AGE (In years last birthday) 86
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY FARMING
11. BIRTHPLACE (City and state or country) MO MACON COUNTY
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME DAVID FULLER
14. MOTHER'S MAIDEN NAME SALLY PINKERMAN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. NONE
17. INFORMANT CLARENCE FULLER Address CLARENCE MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 1 month
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 2 years
DUE TO (c) Chronic Cardiovascular Renal Heart Disease — 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201
19. WAS AUTOPSY PERFORMED? YES ☐ NO X 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from March 1956 to March 18 1957 and last saw NOT him alive on Mar. 18, 1957
Death occurred at 3:00 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE B. L. Edrington D.O. (Degree or title)
22b. ADDRESS Clarence, Mo.
22c. DATE SIGNED 3-21-57

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 3-21-57
23c. NAME OF CEMETERY OR CREMATORY MT ZION CEMETERY
23d. LOCATION (City, town, or county) MACON COUNTY (State) MO
24. FUNERAL DIRECTOR Chas V. Greening ADDRESS Clarence Mo
25. DATE RECD. BY LOCAL REG. 3-23-57
26. REGISTRAR'S SIGNATURE Ada Garrison

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

419-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed Charles V. Greenw

Licensed Embalmer No. 46

P. O. Address Clarence

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.