V.S. No. 300
Rev. 10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11968

BIRTH NO. _____ REG. DIST. NO. 4 PRIMARY REG. DIST. NO. 4012 Registrar's No. 37

1. PLACE OF DEATH
a. COUNTY: Atchison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rock Port/
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): None

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Atchison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rock Port.
d. STREET ADDRESS (If rural, give location): 0030 0 none

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle): August
c. (Last): Fuller

4. DATE OF DEATH (Month) (Day) (Year): 4-26-1957

5. SEX: O Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 6-20-1869
9. AGE (In years last birthday): Months 87 Days 10 Hours 6 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Bethany. Mo.,
12. CITIZEN OF WHAT COUNTRY? US
13a. FATHER'S NAME: Mathew Fuller
13b. MOTHER'S MAIDEN NAME: Rebecca Harris
14. NAME OF HUSBAND OR WIFE: Susan Fuller
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'S SIGNATURE OR NAME: Mr Walter Doiel ADDRESS: Rock Port.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 min

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Coronary Arteriosclerosis — 5 years

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: 4201
20. AUTOPSY? O YES ☐ NO ☐

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):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug., 1952 *to* 4-26-, 1957, *that I last saw the deceased alive on* 4-26-, 1957, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wallace Carpenter (Degree or title) MD
23b. ADDRESS: Rock Port Mo
23c. DATE SIGNED: 4-27-57

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 4-29-1957
24c. NAME OF CEMETERY OR CREMATORY: High Creek, Cem.
24d. LOCATION (City, town, or county) (State): Watson. Mo.,

DATE REC'D BY LOCAL REG.: April 29, 1957
REGISTRAR'S SIGNATURE: Marion H. Schooler
25. FUNERAL DIRECTOR'S SIGNATURE: Bartholomew Mortuary. ADDRESS: Rock Port.
(Licensed Embalmer's Statement on Reverse Side)

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

443 0

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 Gratz Bartholomew

Licensed Embalmer No. 3173

P. O. Address Rock Port, 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.