

Dept. Health,
J. S. Public
Health Service

FILED JAN 9 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43613
STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 2007 Registrar's No. 88

V. S. 300
Rev. 1-57

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Butler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Carter</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Ellisnore Mo</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR CLINIC <u>Chambers Clark's Rest Home</u>		Length of stay in 1b <u>4 yr.</u>	d. STREET ADDRESS (If outside, give location) <u>Reside on Farm</u> Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grover Cleveland Fuller</u>			4. DATE OF DEATH Month Day Year <u>Dec. 24 1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9th 1885</u>
9. AGE (In years last birthday) <u>72</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Retired laborer</u>	11. BIRTHPLACE (City and state or country) <u>Carter Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. NAME OF HUSBAND OR WIFE <u>Fannie A. Leach (Deceased)</u>	
13a. FATHER'S NAME <u>Abraham B. Fuller</u>		13b. MOTHER'S MAIDEN NAME <u>Eliza Gourley</u>	
14. NAME OF HUSBAND OR WIFE <u>Fannie A. Leach (Deceased)</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>432-44-1101A</u>		17. INFORMANT Address <u>Mrs. Lane Carman Piedmont Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u>			<u>15 yrs.</u>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Moderate Hypertension</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>8 May 56</u> to <u>24 Dec 57</u> and last saw him alive on <u>23 Dec 57</u> Death occurred at <u>24 Dec 57</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Type or print) <u>Cyril A. Post M.D.</u>		22b. ADDRESS <u>Poplar Bluff, Mo</u>	
22c. DATE SIGNED <u>4 Jan 57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-28-57</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>Kearby</u>		23d. LOCATION (City, town, or county) (State) <u>Butler Co. Mo.</u>	
24. FUNERAL DIRECTOR <u>William Coder</u>		25. DATE RECD. BY LOCAL REG. <u>1/4/58</u>	
26. REGISTRAR'S SIGNATURE <u>Prumetree</u>			

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

JAN 6 1958

JAN 6 1958
BUTLER CO. HEALTH CENTER

FILE No. _____

JAN 10 1958

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 Coder Funeral Home, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William Coder

Licensed Embalmer No. 3723

P. O. Address Baldmont, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.