

S. 300  
v. 1156  
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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 30 1957

46806

STATE FILE NUMBER

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 3099

1. PLACE OF DEATH a. COUNTY <b>St. Louis, Co.</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
-b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Manchester</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>37 Pine Crest Nursing Home</b>		Length of stay in 1b <b>4 YEARS, 25</b>	STREET ADDRESS <b>10th &amp; Market</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>William Fullington</b>			4. DATE OF DEATH <b>Dec. 6 57</b>		Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 23 1888</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>13</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Park Department</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City St. Louis</b>	11. BIRTHPLACE (City and state or country) <b>Jackson Tenn</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Tom Fullington</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>416-12-6702</b>		17. INFORMANT <b>Agnes Duval 1433 Destrehan St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Interstitial Nephritis</b> DUE TO (b) <b>Chronic - Myocarditis</b> DUE TO (c) <b>Arterio Sclerosis H2021</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)					INTERVAL BETWEEN ONSET AND DEATH
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 <b></b> Month <b></b> Day <b></b> Year <b></b> a. m. <b></b> p. m. <b></b>					
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 <b>Sept 6 - 53 to Dec 6 - 57</b> and last saw her alive on <b>Dec 4/57</b> Death occurred at <b>9:06 P.M. Dec. 6 1957</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Richard H. Jausan M.D.</b>			22b. ADDRESS <b>1726 del Norte Richmond 1475 17 Ave.</b>		22c. DATE SIGNED <b>Dec 7/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Dec 9 - 57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Matthewz</b>		23d. LOCATION (City, town, or county) (State) <b>St Louis Mo</b>
24. FUNERAL DIRECTOR <b>Louis H. Bopp Inc</b>		25. DATE RECD. BY LOCAL REG. <b>12-9-57</b>		26. REGISTRAR'S SIGNATURE <b>Robert B. Hamble MD</b> <b>ccc</b>	

(Licensed Embalmer's Statement on Reverse Side)

APR 10 1910

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 *Francis J. Wood*  
Licensed Embalmer No. 45

P. O. Address *Wickwood*

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.