

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023896
STATE FILE NUMBER

FILED JUN 23 1959 Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 133

5. 300
7. 1-57

1. PLACE OF DEATH a. COUNTY <i>Vernon</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Cedar</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Nevada</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>El Dorado Springs</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>City Hospital</i>		Length of stay in lb <i>3 days</i>	d. STREET ADDRESS (If outside, give location) <i>115 Broadway</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Walter Earl Fullerton</i>			4. DATE OF DEATH Month Day Year <i>June 17, 1959</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 8, 1886</i> <i>9-18-1886</i>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>72</i> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher (retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>St. Clair Co., Mo.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>John Fullerton</i>		13b. MOTHER'S MAIDEN NAME <i>Amanda Griffith</i>		14. NAME OF HUSBAND OR WIFE <i>Fannie Fullerton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <i>El Dorado Spgs. Mo.</i> <i>Mrs. Fannie Fullerton</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <i>Cerebral arteriosclerosis</i>			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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.		ITEM 8 CORRECTED BY AFFIDAVIT OF Funeral Director <i>7-13-59</i>			
20d. INJURY OCCURRED WHILE AT <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 Death occurred at <i>7:10</i>		<i>6-11-59</i> to <i>6-17-59</i> and last saw him alive on <i>6-17-59</i>			
22a. SIGNATURE (Degree or title) <i>Robert W. Magee M.D.</i>		22b. ADDRESS <i>El Dorado Springs, Mo.</i>		22c. DATE SIGNED <i>6-18-59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-19-1959</i>		23c. NAME OF CEMETERY OR CREMATORY <i>El Dorado Springs Cem.</i>	
24. FUNERAL DIRECTOR <i>Guinn-Crothers</i>		ADDRESS <i>El Dorado Spgs. Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>6-19-1959</i>	
				26. REGISTRAR'S SIGNATURE <i>Anna J. Ferry</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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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 *E. J. Caathur*

Licensed Embalmer No. *74-19*

P. O. Address *E. J. Caathur*

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: -