

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-026246

STATE FILE NUMBER

FILED VS JUL 27 1959

Registration District No. 390 Primary Registration District No. 6041 Registrar's No. 6014

Health,
& Welfare
Public
Service

S. 300
V. 1-56

securing the medical certification in the specific manner required by 193.140 RSMO 1959.
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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Randolph	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR Higbee Mo Moniteau Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Higbee Mo Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb At Home		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Wade H Fullington			4. DATE OF DEATH Month Day Year July 15 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11 1878
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR OF UNDER 24 HRS. Months Days 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	11. BIRTHPLACE (City and state or country) R. F. D. Higbee Mo
13. FATHER'S NAME William Fullington		12. CITIZEN OF WHAT COUNTRY? U. S. A	
14. MOTHER'S MAIDEN NAME Elizabeth Young		17. INFORMANT Address Mrs Wade Fullington Higbee Mo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute circulatory failure			INTERVAL BETWEEN ONSET AND DEATH 1 hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary thrombosis and myocardial infarction			24 hours
DUE TO (c) Arteriosclerosis			Unknown
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 <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 a. m. Month, Day, Year 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 _____ to _____ and last saw him ^{her} alive on 7-15-59 Death occurred at 10:05 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Her. Y. Robinson, D. O.		22b. ADDRESS Higbee, Missouri	22c. DATE SIGNED 7-21-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE July 17 1959	23c. NAME OF CEMETERY OR CREMATORY Huntsville Mo	23d. LOCATION (City, town, or county) (State) Huntsville Mo
24. FUNERAL DIRECTOR ADDRESS Burton Funeral Home Higbee Mo		25. DATE RECD. BY LOCAL REG. 7-21-59	26. REGISTRAR'S SIGNATURE Joe W Burton

(Licensed Embalmer's Statement on Reverse Side)

FEB 26 1967

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: *[Handwritten Signature]*

Licensed Embalmer No. *391*

P. O. Address *Glasgow*

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.