

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041101

FILED VS NOV 21 1960

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b over 20 yrs.		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2528 No. 3rd Street			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EMMETT Middle FULTZ Last FULTZ				4. DATE OF DEATH Month November Day 7 Year 1960			
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 3/2/1881	9. AGE (last birthday) 79 years	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) Ballonia, Indiana		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Peter Fultz			13b. MOTHER'S MAIDEN NAME Martha Overshiner			14. NAME OF HUSBAND OR WIFE Ona Belle Fultz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 500-14-7518-A		17. INFORMANT Mrs. George Grimes, Forest City, Mo. Address _____		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardiac Failure						Unk.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) Cerebral Hemorrhage						Unk.	
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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. _____ p.m.		Month, Day, Year					
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 11/4/60 to 11/7/60 and last saw ^{her} him alive on 11/6/60				Death occurred at 10:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>S.E. Melaney</i> (Degree or title)			22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.			22c. DATE SIGNED 11/8/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/9/1960	23c. NAME OF CEMETERY OR CREMATORY Maitland Cemetery		23d. LOCATION (City, town, or county) Maitland, Missouri		(State)	
24. FUNERAL DIRECTOR <i>Stamcy Funeral Home</i> St. Joseph, Mo. (615)			25. DATE RECD. BY LOCAL REG. Nov. 14, 1960		26. REGISTRAR'S SIGNATURE <i>Wm. Clark Hardell</i>		

DOCUMENT

BY AFFIDAVIT OF S.E. Melaney, M.D. MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles E Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.