

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046062

FILED VS DEC 19 1960

149

Primary Registration District No. 1002 Registrar's No. 5908

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b life - 53 yrs	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3216 E. 8th. St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last MR. ROY FULTON			4. DATE OF DEATH Month Day Year Nov. 22, 1960		
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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 10-30-84	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business agent - ret.	10b. KIND OF BUSINESS OR INDUSTRY Brewery Union	11. BIRTHPLACE (City and state or country) St. Joseph, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Daniel Fulton	13b. MOTHER'S MAIDEN NAME Luella Sharp	14. NAME OF HUSBAND OR WIFE Luaille Fulton
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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. 495-05-5354	17. INFORMANT Mrs. Luaille Fulton - 3216 E. 8th. St.
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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) Resorrhage, gastro. intestinal		3 days.
DUE TO (b) peptic ulcer - recurrent		? yrs
DUE TO (c) arterio sclerotic cardiovascular disease		? yrs
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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	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.)
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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
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21. I attended the deceased from Sept. 1958 to Nov 1960 and last saw her alive on Nov 22 - 1960 Death occurred at 7:30 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul Wright M.D.	22b. ADDRESS 1324 Prof. Bldg.	22c. DATE SIGNED Nov 23 - '60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-26-60	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR Melody-McGilley-Eylar-1800 E. Linwood	25. DATE RECD. BY LOCAL REG. 11-24-60	26. REGISTRAR'S SIGNATURE H. L. Dwyer
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Paul Wright

Dr. Paul
Greg. Blo

V12-1360

Steel. 12-

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James E. Kacklen

Licensed Embalmer No. 457

P. O. Address K. C. G. M.

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.