

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-023638

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 165
FILED JUL 15 1963

VS 300
Rev. 4/59

1 6004

2 0750

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4 0

5 1

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7 0

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9 4200

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12 6-0

13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Missouri b. COUNTY: OREGON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: North Kansas City		Length of stay in 1b 5 Days	c. CITY OR TOWN: Koshkonong Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: North Kansas City Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES WILBUR FULLER			4. DATE OF DEATH Month Day Year JULY 9, 1963
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 4-1-1891
9. AGE (last birthday) 72		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) FARMER		10b. KIND OF BUSINESS OR INDUSTRY SELF	11. BIRTHPLACE (City and state or country) KOSHKONONG, MISSOURI
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME E. ROBERT FULLER	
13b. MOTHER'S MAIDEN NAME SOPHRONIA PRESLEY		14. NAME OF HUSBAND OR WIFE PEARL O. FULLER	
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. ----	17. INFORMANT Address PEARL O. FULLER - KOSHKONONG, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis heart disease</u>			<u>undetermined</u>
DUE TO (c) <u>Arterio sclerosis</u>			<u>undetermined</u>
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 checked="" 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 <u>7-4-1963</u> to <u>7-9-63</u> and last saw him alive on <u>7-9-63</u> Death occurred at <u>4:50 P</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>8400 N Oak</u>	22c. DATE SIGNED <u>7-9-63</u>
23a. BURIAL REMOVAL, (Specify) BURIAL	23b. DATE 7-11-1963	23c. NAME OF CEMETERY OR CREMATORY STATE LINE CEMETERY	23d. LOCATION (City, town, or county) SALEM, ARKANSAS
24. FUNERAL DIRECTOR C. H. BLACKMAN & SON INC. K. C., MO.		25. DATE RECD. BY LOCAL REG. 7-11-63	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

USE BLACK INK OR TYPEWRITER RIBBON

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 Hubert B. Baird

Licensed Embalmer No. 4888

P. O. Address KC 24, Mo

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.