

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-039533

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1916

FILED OCT 23 1963

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>1 day</u>	c. CITY OR TOWN <u>Galloway</u>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>HANDley Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. 3</u>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Claude Clyde Fullington</u>			4. DATE OF DEATH Month Day Year <u>Oct. 16 1963</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1910</u>	9. AGE (last birthday) <u>53</u>	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) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Hartsville Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>FRANK Fullington</u>		13b. MOTHER'S MAIDEN NAME <u>Cordelia Collins</u>		14. NAME OF HUSBAND OR WIFE <u>ANN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>ANN Fullington</u>	
				Address <u>Rt 3 Box 68 Springfield Mo</u>	

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) <u>Acute Congestive Heart Failure</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chr. Asthma</u>	
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	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)	
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20c. TIME OF INJURY Hour Month, Day, Year s.m. p.m.			
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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 10/16/63 to 10/16/63 and last saw him alive on 10/14/63  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Leman W. Brown M.D.</u>	(Degree or title)	22b. ADDRESS <u>311 1/2 College</u>	22c. DATE SIGNED <u>10/18/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-16-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Wright County Mo.</u>
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24. FUNERAL DIRECTOR <u>BERGMAN-Miller-Bledsoe</u>	ADDRESS <u>Hartsville Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-21-63</u>	26. REGISTRAR'S SIGNATURE <u>Bernie Medley</u>
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DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59  
10347  
20390  
3  
4 0  
5 1  
6  
7 0  
8 0  
9 241k  
10  
11  
12 60  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

DEC 5 1963

JAN 22 1964

10/16/63

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 Max L Miller

Licensed Embalmer No. 4720

P.O. Address Manassas, 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.