No. 2
4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 12 1945

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10430

State File No.

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 20

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Richmond, Mo RURAL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Richmond Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Ray
(c) City or town Richmond, RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. # 3
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Ruth Arnilda Fuller
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 20 (Day) 1862 (Year)

8. AGE: Years 83 Months 4 Days — If less than one day hr. min.

9. Birthplace Ray Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

MOTHER
12. Name Julia Boyer
13. Birthplace Virginia (City, town, or county) (State or foreign country)

FATHER
14. Maiden name Thompson
15. Birthplace Virginia (City, town, or county) (State or foreign country)

16. (a) Informant Ethel Fuller
(b) Address Richmond Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 24 45 (Month) (Day) (Year)
(c) Place: burial or cremation Donkey
18. (a) Signature of funeral director Hall & Lockard
(b) Address
19. (a) Mar 20 1945 (Date received local registrar) (b) Mrs Thos W Shepard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22
year 1945 hour 3 minute 25 A.M.

21. I hereby certify that I attended the deceased from Jan 25, 19 45, to Mar 20, 19 45
that I last saw h alive on Mar 18, 19 45
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to: Advanced Arterio Sclerosis	5 yrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature G W Gaines (M.D. or other)
Address Richmond Mo. Date signed 3-20-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 4/10/45

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was not embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2194

P. O. Address Cowgill 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 this body is not embalmed, fact should be so stated above.