

STANDARD CERTIFICATE OF DEATH

State File No. 14382

Registration District No. 249 Primary Registration District No. 4140

Registrar's No.

1. PLACE OF DEATH:

(a) County DAVIESS
 (b) City or town ALTAMONT
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community LIFE
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DAVIESS
 (c) City or town ALTAMONT
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 5th
 year 1941 hour 2.00 minute A M.

21. I hereby certify that I attended the deceased from Dec 10th,
40 18 Feb 5th 41
18 Feb 4th 41
 that I last saw him alive on _____, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death:

Carcinoma Prostate

Duration

Estima-
ted
3yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings: Exploratory operation
 Of operations: 1938. Inoperable carcino
ma prostate & bladder
 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 Frank Wilson (M. D. or other) D
 Address Winston, Mo Date signed 2/2/41

3. (a) PRINT

FULL NAME WILLIAM ARTHUR CULVER

3. (b) If veteran,

name war NONE

3. (c) Social Security

No. NONE

4. Sex MALE 5. Color or race W. 6. (a) Single, widowed, married,
 divorced MARRIED

6. (b) Name of husband or wife ELLA CULVER 6. (c) Age of husband or wife ifalive 64 years7. Birth date of deceased MAY 18 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 8 17 _____ hr. _____ min.

9. Birthplace DAVIESS CO MO
(City, town, or county) (State or foreign country)10. Usual occupation FARMER

11. Industry or business _____

12. Name ELI CULVER13. Birthplace MO. D
(City, town, or county) (State or foreign country)14. Maiden name MARY LEBO15. Birthplace MO. D
(City, town, or county) (State or foreign country)16. (a) Informant MRS. ELLA CULVER(b) Address ALTAMONT MO.17. (a) BURIAL (b) Date thereof 2/7/41
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation MC CRAWY CFM.18. (a) Signature of funeral director E. M. Jordan(b) Address Winston, Mo.19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

STATE OF MISSISSIPPI

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.....
..... Registered Apprentice No.....
working under my personal supervision.

Signed *E. M. Jones*
Licensed Embalmer No. 3453
P. O. Address Yallahs, MS

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 248

Primary Registration District No. 4148

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Daviess
(b) City or town Altamont
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Wm Arthur Culver
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____
7. Birth date of deceased. _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 62 Months 8 Days 19 If less than one day _____ hr _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____ (City, town, or county) _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-16-41 (b) Mrs F L Reich
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 8
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Fred K. Wilson (M. D. or other) _____

Address Winston _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

S-14382