

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4785
Registrar's No. 804

Registration District No. 449

Primary Registration District No. 1005

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: RESEARCH HOSPITAL 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 DAYS (Specify whether
In this community 40 YEARS. years, months or days)

3. (a) PRINT FULL NAME CARLOS ADA CULP
3. (b) If veteran, name war No
3. (c) Social Security No. 487-01-2202

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MRS. HATTIE KEE CULP
6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased OCTOBER 20 1880
(Month) (Day) (Year)

8. AGE: Years 67 Months 4 Days 1
If less than one day hr. min.

9. Birthplace SAWANA KANSAS 1
(City, town, or county) (State or foreign country)

10. Usual occupation AUDITOR (RETIRED - 7 YEARS)

11. Industry or business GREINER-FIELD LITHOGRAPHING CO.

12. Name CHARLES C. CULP

13. Birthplace OHIO 1
(City, town, or county) (State or foreign country)

14. Maiden name CLARA F. NICKLES

15. Birthplace OHIO 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. L. Summers

(b) Address 3914 W. 52nd Terrace

17. (a) BURIAL (b) Date thereof FEB. 23, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

18. (a) Signature of funeral director L. W. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 2-23-48 (b) Aleraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State KANSAS (b) County JOHNSON 99
(c) City or town MISSION
(If outside city or town limits, write "RURAL")
(d) Street No. 5723 BIRCH STREET
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBRUARY day 21⁹⁷
year 1948 hour 2 minute 10 P.M.

21. I hereby certify that I attended the deceased from October 1947 to February 21, 1948
that I last saw him alive on February 21 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Pneumonia Duration 5 days
due to long standing emphysema and bronchiectasis, hypertension, heart disease, cardiac-renal disease, aortic atherosclerosis
Due to 1310

Other conditions Acute duodenal ulceration
(Include pregnancy within 3 months of death)

Major findings: Acute renal failure - Bilateral terminal pneumonia - Chronic myocarditis, hypertensive atherosclerosis, acute duodenal ulceration
Of autopsy Chronic myocarditis, hypertensive atherosclerosis, acute duodenal ulceration
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 A. B. Derrington (M. D. or other) MD
Address 5827 Red Rock Date signed 2/23/48

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

MOTHER FATHER

9:00 a.m.
Starrick

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

Edward M. Starrick

Licensed Embalmer No. *4452*

P. O. Address *K.C. 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.