

FILED DEC 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42155

BIRTH NO. _____		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>3058</u>		Registrar's No. <u>234</u>		
1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Charles</u>		c. LENGTH OF STAY (in this place) <u>3 8 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Charles</u>		12		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>429 Houston Street</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank</u>		b. (Middle) <u>G.</u>		c. (Last) <u>Cullom</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 10-1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 28-1887</u>		
9. AGE (In years last birthday) <u>62</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 10 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Merchant (retired)</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Warren County, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Thomas Cullom</u>			13b. MOTHER'S MAIDEN NAME <u>Naomi Clyce</u>			14. NAME OF HUSBAND OR WIFE <u>Fannie L. (Cullom) Cullom</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. <u>NIL</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Melvin Cullom (son) St. Charles, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Hypertensive Cardio-Vascular Disease</u>					3 yrs.	
		DUE TO (c) <u>Gen. Arterio Sclerosis.</u>					5 yrs.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							743X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>12-5-</u> , <u>189</u> , to <u>12-10-</u> , <u>1949</u> , that I last saw the deceased alive on <u>12-10-</u> , <u>1949</u> , and that death occurred at <u>5:45 A.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>R. J. Prudde</u>				23b. ADDRESS <u>126 S. Main St.</u>		23c. DATE SIGNED <u>12/10/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec 13-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak-Grove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Charles, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>12-23-49</u>		REGISTRAR'S SIGNATURE <u>Fannie H. Hume</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H. C. Dollmeyer + Sons Co</u> <u>800 N. 2nd - St. Charles, Mo.</u>				

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

RECEIVED DEC 27 1949
District Health Officer No. 9,
District File Number

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 _____
Student Embalmer

Signed _____

Joseph I. Landolt

Licensed Embalmer No. 4189

P. O. Address _____

St. Charles 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.