

FILED OCT 21 1950

STANDARD CERTIFICATE OF DEATH

State File No. 34707
7673

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) UNIVERSITY CITY <u>4336</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LUKES HOSPITAL		d. STREET ADDRESS (If rural, give location) 7539 MARYLAND <u>1</u>	

3. NAME OF DECEASED (Type or Print) a. (First) LINN b. (Middle) N. c. (Last) CULBERTSON.			4. DATE OF DEATH (Month) (Day) (Year) Sept. 9 1950		
5. SEX Male <u>0</u>		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH March 16, 1890		9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Treasurer, Hess & Culbertson Jewl. Co. St. Louis, Mo.	
11. BIRTHPLACE (State or foreign country) <u>0</u>		12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME Stephen D. Culbertson.		13b. MOTHER'S MAIDEN NAME Mary Eliza Hess.		14. NAME OF HUSBAND OR WIFE Martha K. Culbertson.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes. W.W.I		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME. ADDRESS Martha K. Culbertson; 7539 Maryland	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage (left side of Brain)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Cerebral Arteriosclerosis			
		DUE TO (c) Arterial Hypertension			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X	

22. I hereby certify that I attended the deceased from August, 1943, to Sept. 9, 1950, that I last saw the deceased alive on Sept. 9, 1950, and that death occurred at 9 P m., from the causes and on the date stated above.

23a. SIGNATURE Hiram L. Light		(Degree or title) M.D.		23b. ADDRESS 3720 Washy L. Blvd.	
23c. DATE SIGNED 9/10/50					

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-12-1950		24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery, St. Louis, Mo.	
24d. LOCATION (City, town, or county) (State)					

DATE REC'D BY LOCAL REG. SEP 11 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.R. Lupton & Sons; 7233 Delmar Blvd;	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Clarence H. Murray*
Licensed Embalmer No *4011*

P. O. Address *St. Louis, 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.