

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **36519**

FILED OCT 26 1953

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 365

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Oakwood</u>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>Oakwood</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Residence 3405 St. Charles</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) <u>3405 St. Charles</u>	

3. NAME OF DECEASED (Type or Print) <u>Mahala Anna Culbertson</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>October 15, 1953</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>October 5, 1869</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.	IF UNDER 24 HRS. Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>

13a. FATHER'S NAME <u>George Hall</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Jane Eddington</u>	14. NAME OF HUSBAND OR WIFE <u>James B. Culbertson</u>
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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>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. T. G. Harley</u>	ADDRESS <u>Oakwood Missouri</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>2 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Central Hemorrhage</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c)		
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 <u>331X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>Hannibal Missouri</u>
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 Oct 1, 1953, to Oct 15, 1953, that I last saw the deceased alive on Oct 15, 1953, and that death occurred at 6:50 Am., from the causes and on the date stated above.

23a. SIGNATURE <u>Glenn R. Miller D.O.</u>	(Degree or title)	23b. ADDRESS <u>Hannibal Mo.</u>	23c. DATE SIGNED <u>Oct 16, 1953</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10/17/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>	24d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>
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DATE REC'D BY LOCAL REG. <u>10-22-53</u>	REGISTRAR'S SIGNATURE <u>W.C. Miller</u>	25. FEDERAL DIRECTOR'S SIGNATURE <u>W.C. Miller</u>	ADDRESS <u>Hannibal Missouri</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

OCT 23 1953

RECEIVED

MARION CO. HEALTH DEPT.

DATE FILED OCT 23 1953

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.....
Signature of Student Embalmer

Signed *H Crawford Smith*

Licensed Embalmer No. 381

P. O. Address Hannibal 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.