

FILED OCT 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30723**
Registrar's No. **8542**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS.		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL.		e. STREET ADDRESS (If rural, give location) 1818 Kennett Place	

3. NAME OF DECEASED (Type or Print) EMIL CULLMANN			4. DATE OF DEATH SEPT. 10, 1955		
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH DEC. 6, 1890.	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELFARE RELIEF		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) MISSOURI	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					

13a. FATHER'S NAME ?		13b. MOTHER'S MAIDEN NAME ?		14. NAME OF HUSBAND OR WIFE ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?		17. INFORMANT'S SIGNATURE OR NAME Hospital records	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) STAPHYLOCOCCAL PYELONEPHRITIS & PNEUMONIA ANTECEDENT CAUSES DUE TO (b) UREMIA DUE TO (c) NEPHROSCLEROSIS, PROBABLE MYOCARDIAL INFARCTION II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 446 X		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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?	

22. I hereby certify that I attended the deceased from **8, 14**, **1955**, **SEPT. 10**, **1955**, that I last saw the deceased alive on **9-10**, **1955**, and that death occurred at **11:20 AM**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) MD		23b. ADDRESS 1515 LAFAYETTE AVE.		23c. DATE SIGNED 9-12-55	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 9.30-55		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.			

DATE REC'D BY LOCAL REG. SEP 29 1955		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service ADDRESS 4104 M. Manchester Ave. St. Louis 10, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Licensed Embalmer No.....

P. O. Address.....

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.