

of Health,  
& Welfare  
S. Public  
Health Service

S. 300  
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUL 17 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **26947**  
Registration District No. **317** Primary Registration District No. **590** Registrar's No. **1501**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ladue</b>		c. CITY OR TOWN <b>Ladue</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>11 Warson Terrace</b>		d. STREET ADDRESS (If outside, give location) <b>11 Warson Terrace</b>	
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>R.</b> Last <b>Culp</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12</b> , Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Mechanicsburg, Ill.</b>
13. FATHER'S NAME <b>William Logan Hall</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Frank O. Watts, 11 Warson Terrace</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO (b) <b>Arteriosclerosis, Generalized</b> DUE TO (c) <b>Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>Hemiplegia - rt. - 4 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>10 yrs.</b> <b>15 yrs.</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>7/21/41</b> to <b>6/12/57</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>6/11/57</b> Death occurred at <b>1:30 a m</b> m on the date stated above; and to the best of my knowledge, from the causes stated			
22a. SIGNATURE (Degree or title) <b>Harry Ogden MD</b>		22b. ADDRESS <b>634 N. Grand</b>	
22c. DATE SIGNED <b>6/12/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>6-12-57</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		23d. LOCATION (City, town, or county) (State) <b>Springfield, Ill.</b>	
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>6-12-57</b>	
26. REGISTRAR'S SIGNATURE <b>Herbert B. Donke MD</b>			

61.

St. Louis  
 Licensee  
 II  
 2 yrs.  
 White  
 At Home  
 William Logan Hall  
 Licensee  
 II  
 2 yrs.  
 White  
 At Home  
 William Logan Hall  
 Licensee  
 II  
 2 yrs.  
 White  
 At Home  
 William Logan Hall

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 *John L. Blenke*  
 Licensed Embalmer No. *419*  
 P. O. Address *St. Louis*

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.