

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

**2325**

STATE FILE NUMBER

**FILED JAN 28 1958**

Registration District No. **278** Primary Registration District No. **3054** Registrar's No. **4**

health, Welfare, Public Service  
300  
1-56  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Pike</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Louisiana</b>		c. CITY OR TOWN <b>Louisiana</b>		d. STREET ADDRESS <b>615 Maryland</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Length of stay in lb <b>65 years</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print)				<b>4. DATE OF DEATH</b>			
First <b>OLLIE</b>		Middle <b>M</b>		Last <b>CULLING</b>		Month <b>JAN.17</b> , Year <b>1958</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 27, 1883</b>		<b>9. AGE</b> (In years last birthday) <b>74</b>	
IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Housekeeping</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Indiana</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S.</b>							
<b>13. FATHER'S NAME</b> <b>Robert W. Dilger</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> Address <b>Mr. M. A. Culling, Louisiana, Mo.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery occlusion</b>							<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							<b>10 yrs.</b>
DUE TO (b) <b>Hypertensive cardio-vascular disease</b>							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
-----							<b>4201</b>
<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) -----				
<b>20c. TIME OF INJURY</b> Hour _____ Month _____, Day _____, Year _____ a. m. _____ p. m. _____			-----				
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e. g., in or about home, farm, factory, street, office bldg., etc.) -----		<b>20f. CITY, TOWN, OR LOCATION</b> -----		<b>COUNTY</b> ----- <b>STATE</b> -----	
<b>21. I attended the deceased from</b> <b>1/7/55</b> , to <b>1/17/58</b> and last saw her alive on <b>1/17/58</b> <b>Death occurred at</b> <b>11:30</b> <b>A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>Chas. H. Lavelle M.D.</b>				<b>22b. ADDRESS</b> <b>Louisiana, Missouri</b>		<b>22c. DATE SIGNED</b> <b>1/17/58</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>1/19/58</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Riverview Cemetery</b>		<b>23d. LOCATION (City, town, or county) (State)</b> <b>Louisiana, Mo.</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>sterne funeral Home, Louisiana, Mo.</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>Jan 18, 1958</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Bernice Cullen</b>	

OCT 30 1904

**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.....*Virginia M. Stern*

Licensed Embalmer No. 4648

P. O. Address *Louisiana*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.