

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021641

STATE FILE NUMBER

FILED JUN 23 1958

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 613

300
-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield 0396 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1623 Irving Ave.		Length of stay in 1b 6 months	d. STREET ADDRESS (If outside, give location) 1010 N, Campbell Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LAURA Middle KATHERINE Last VanHoose			4. DATE OF DEATH Month June Day 12 Year 1958			
--	--	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 26 May 1897	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	---	--	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Sioux Falls, South Dakota	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	--	--	---

13a. FATHER'S NAME Edward G. Culp	13b. MOTHER'S MAIDEN NAME Margaret E. Ullman	14. NAME OF HUSBAND OR WIFE Frank Van Hoose
---	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) No None	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Clarence T. Beem, Springfield, Mo. Address: 1010 N. Campbell,
--	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Malnutrition		INTERVAL BETWEEN ONSET AND DEATH Several years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Sigmoido-epithelial Sinus	10 years
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) NOTE: Refused all medical care throughout entire course of illness.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 _____ 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 6-11-58 ^{ON} seen only once and last saw her alive on 6-11-58 c. Death occurred at 12 45/P m on the date stated above; and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE Albert P. Simpson, M.D. (Degree or title)	22b. ADDRESS 301 Springfield Med. Bldg. Springfield, Mo.	22c. DATE SIGNED 6-12-58
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-14-1958	23c. NAME OF CEMETERY OR CREMATORY Eastlawn	23d. LOCATION (City, town, or county) (State) Springfield, Mo.
--	-------------------------------	---	--

24. FUNERAL DIRECTOR Ralph Pieme, Springfield, Missouri.	ADDRESS	25. DATE RECD. BY LOCAL REG. 6-17-58	26. REGISTRAR'S SIGNATURE G. G. Ornelo
--	---------	--	--

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 *Lee Mason*

Licensed Embalmer No. 4568
Springfield,
P. O. Address Missouri,

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.