

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035442
STATE FILE NUMBER

FILED OCT 20 1958 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 458

Health, Welfare Public Service
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

1. PLACE OF DEATH a. COUNTY Boone				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Scott			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Sikeston			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION University Medical Center			Length of stay in lb 46 days	d. STREET ADDRESS Box 465			(If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Hollos Middle Wilson Last Culp				4. DATE OF DEATH Month 10 Day 14 Year 58			
5. SEX Male	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 8/21/95		9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months 6 Days 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electric Shop		11. BIRTHPLACE (City and state or country) Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leonaad W. Culp				14. MOTHER'S MAIDEN NAME Fannie O'Bryan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT, Address Patients Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL HEMORRHAGE							INTERVAL BETWEEN ONSET AND DEATH Recent
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) GASTRIC ULCER.							
DUE TO (c) HODGKINS DISEASE 201XA							24 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 1
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 9:45 Month 10 Day 14 Year 58 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 3-11-57 to 10-14-58 and last saw her/him alive on 10-14-58 Death occurred at 9:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) John F. Lowrey M.D.				22b. ADDRESS University of Missouri		22c. DATE SIGNED 10-14-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 10-14-58	23c. NAME OF CEMETERY OR CREMATORY Sikeston Cemetery		23d. LOCATION (City, town, or county) (State) Sikeston, Missouri		
24. FUNERAL DIRECTOR ADDRESS Lyman Sprinkle Columbia, Mo.			25. DATE RECD. BY LOCAL REG. Oct 14, 1958		26. REGISTRAR'S SIGNATURE Mrs R E Palmer		

NOV 9 1956

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.....
Lynnard H. Spence

Licensed Embalmer No. 407

P. O. Address Columbia

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.