

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -61-038436

DEPARTMENT OF PUBLIC HEALTH AND WELFARE
 AMENDED Registration District No. 218 Primary Registration District No. 1003 Registrar's No. 9417 STATE FILE NUMBER

FILED OCT 26 1961

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b | c. CITY OR TOWN <u>St. Louis</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>3958 St. Ferdinand</u> |
| 3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle Last <u>Culpepper</u> | | 4. DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>61</u> | |

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|---|----------------------------------|---|-------------------------------------|--|---|--|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-9-1906</u> | 9. AGE (last birthday) <u>55</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | | 11. BIRTHPLACE (City and state or country) <u>St. Joseph, Louisiana</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> |
| 13a. FATHER'S NAME <u>Unknown</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>John Culpepper</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Susie Davis</u> Address <u>3846 Kennerly</u> | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:

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| IMMEDIATE CAUSE (a) <u>Pulmonary Emboli</u> | INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Metastatic Carcinoma of Lungs</u> | <u>Undet.</u> |
| DUE TO (c) <u>Carcinoma of Uterus</u> <u>174x</u> | <u>Undet.</u> |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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. | Month, Day, Year | | |
| 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 10-5-61 to 10-7-61 and last saw her ^{her} ~~him~~ alive on 10-7-61
 Death occurred 6:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22. SIGNATURE <i>George D. Francis M.D.</i> (Name or title) | 22b. ADDRESS <u>2601 N. Whittier Street</u> | 22c. DATE SIGNED <u>10-9-61</u> |
|---|--|------------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>10-15-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County</u> |
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| 24. FUNERAL DIRECTOR <u>C. B. Roan</u> ADDRESS <u>221 N. Grand</u> | 25. DATE RECD. BY LOCAL REG. <u>OCT 11 1961</u> | 26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i> |
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INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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 Malvin Blackburn

Licensed Embalmer No. 3967

P. O. Address 1221 N. 2nd

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.