

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-010247

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 31

STATE FILE NUMBER

FILED MAR 26 1963	
1. PLACE OF DEATH	
a. COUNTY <u>Atchison</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fairfax</u>	a. STATE <u>Missouri</u> COUNTY <u>Atchison</u>
Length of stay in 1b <u>6wks</u>	c. CITY OR TOWN <u>Tarkio</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fairfax Comm Hospt</u>	d. STREET ADDRESS (If outside, give location) Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED	
First <u>Maude</u> Middle <u>May</u> Last <u>Culp</u>	4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1963</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/1881</u>
9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) <u>Albany Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S</u>
13a. FATHER'S NAME <u>James E Malcom</u>	13b. MOTHER'S MAIDEN NAME <u>Elinor Steigelman</u>
14. NAME OF HUSBAND OR WIFE <u>Freeman F. Culp</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 Address <u>Mrs. Gavin Doughty Tarkio, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause if PART I. DEATH WAS CAUSED BY)	
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Acute virus upper respiratory infection</u>
	DUE TO (c) <u>Acute virus pneumonia</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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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. 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 <u>12/15/62</u> to <u>3/9/63</u> and last saw <u>her</u> alive on <u>3/9/63</u>	
Death occurred at <u>8 30 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>Tarkio, Mo.</u>
22c. DATE SIGNED <u>3/10/63</u>	
23a. BURIAL CREATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>3/11, 1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	
23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Davis Funeral Home Tarkio, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>March 23, 1963</u>
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

VS 300 Rev. 4/59
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4 1
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13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

3-1

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

Frost Q. Browning

Licensed Embalmer No. 3338

P. O. Address Tarkio, Mo.

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.