

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-047968

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 6694

FILED DEC 27 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1

23488

3

4 0

5 0

6

7 1

8 1

9491KH

10

11

1276-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>3 yrs</b>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V A HOSPITAL</b>		Inside limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>315 W. 38th Berkley Hotel</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOSIAH</b> Middle <b>CULLOM</b> Last			4. DATE OF DEATH Month <b>December</b> Day <b>6</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-10-92</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired hotel worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lead, S. Dak.</b>	9. AGE (last birthday) <b>71</b> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR: Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>Lead, S. Dak.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Richard Henry Cullom</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Ann Oliver</b>	
14. NAME OF HUSBAND OR WIFE <b>---</b>		17. INFORMANT <b>Hazel Trusler, same address</b> Address <b>VA Hospital Official Records, K.C. Mo.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia and pulmonary edema</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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>Carcinoma of pancreas with metastases</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 _____ s.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. <b>VA</b> attended the deceased from <b>October 31, 1963</b> to <b>December 6, 1963</b> Death occurred at <b>9:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>R. H. OWINGS, M.D.</b>		22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>	22c. DATE SIGNED <b>12-9-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-12-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Leavenworth Nat'l.</b>	23d. LOCATION (City, town, or county) (State) <b>Ft. Leavenworth, Kansas</b>
24. FUNERAL DIRECTOR <b>Mellody-McGilley-Eylar Funeral Home</b> <b>Linwood &amp; Woodland, Kansas City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-10-63</b>	26. REGISTRAR'S SIGNATURE <b>Bessie Smith</b>

(Attach Embalmers' Statement on Reverse Side)

99970-102

HOSPITAL

ELIO BARNI

1000 ...

...

...

A. B. U.

...

...

...

...

HOSPITAL

ELIO BARNI

MATTHEW A. V.

...

...

...

...

...

...

8846

STATEMENT BY LICENSED EMBALMER

0-27

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 James E. Hackleman

Licensed Embalmer No. 4573

P. O. Address R. C. ...

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.

2-1-51