

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-047969  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6777  
FILED DEC 27 1963

VS 300  
Rev. 4/59

1

2 3118

3 2

4 0

5 1

6

7 1

8 2

9 9420.1

10

11

12 54-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
Leo M. Mullen

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>1 year</u>	c. CITY OR TOWN <u>Kansas City</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>Downtown Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1014 Broadway Apt-306</u>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Leroy</u> Last <u>Culver</u>			4. DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>9-14-1914</u>	9. AGE (last birthday) <u>49</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tractor Supply Co.</u>		11. BIRTHPLACE (City and state or country) <u>Creston, Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>Alva C. Culver</u>		13b. MOTHER'S MAIDEN NAME <u>Esther Wilson</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Garnet Rose Culver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W. II</u>			16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address <u>Mrs. Garnet R. Culver-1014 Broadway-K.C., Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cononary Thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>48 Hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cononary &amp; Generalized Arteriosclerosis</u>					
DUE TO (c) <u>Arteriosclerosis</u>					<u>1 Year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Duodenal Ulcer</u>				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 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 <u>Afton, Iowa</u>	COUNTY _____ STATE _____	
21. I attended the deceased from <u>3-8-1963</u> to <u>12-14-1963</u> and last saw him <sup>xxx</sup> alive on <u>12-14-1963</u> Death occurred at <u>11:30</u> p. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Dr. Leo M. Mullen</u> (Degree or title)			22b. ADDRESS <u>4443 Paseo-Kansas City, Mo.</u>		22c. DATE SIGNED <u>12-14-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-15-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>	23d. LOCATION (City, town, or county) <u>Afton, Iowa</u>	(State)	
24. FUNERAL DIRECTOR <u>D.W. Newcomer's Sons-North Kansas City, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>12-14-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>	

(Licensed Embalmer's Statement on Reverse Side)

Dr. Leo M. Mullen M.D.  
4443 Paseo  
Wa 3-7230

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

*Marvin D. Preston*

Licensed Embalmer No.

*5040*

P. O. Address

*No. Kan. City, 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.