V. S. No. 2
50M—5-42
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 15 1944

Registration District No. 233

STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

25849

State File No.

Primary Registration District No. 3074

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County: Scott
(b) City or town: Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sikeston General
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 days (Specify whether years, months or days)
In this community: Six Months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: New Madrid
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: 4 miles So. Of Sikeston
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Alvin James Culwell

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: S

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: 7 (Month) 24 (Day) 1932 (Year)

8. AGE: Years 11 | Months 10 | Days 22 | If less than one day: hr. min.

9. Birthplace: Searcy Co. (City, town, or county) Ark. (State or foreign country)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: J.A. Culwell
13. Birthplace: Madison Co. (City, town, or county) Ark. (State or foreign country)

MOTHER
14. Maiden name: Mandy Thompson
15. Birthplace: Searcy Co. (City, town, or county) Ark. (State or foreign country)

16. (a) Informant: J.A. Culwell
(b) Address: Sikeston Mo. R.F.D. # 3

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/17/44 (Month) (Day) (Year)
(c) Place: burial or cremation: Sikeston Mo.

18. (a) Signature of funeral director: H.W. Albritton
(b) Address: Sikeston Mo.

19. (a) 8/6/44 (Date received local registrar) (b) Lonie Largent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 16 year 1944 hour 6 minute p.M.

21. I hereby certify that I attended the deceased from 6-13-44, 19..., to 6-16, 1944 that I last saw him alive on 6-16, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: intracranial hemorrhage — Duration

Due to: skull fracture

Due to:

Other conditions: none
(Include pregnancy within 3 months of death)

Major findings:
Of operations: —

Of autopsy: —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): Accident
(b) Date of occurrence: 6/13/44
(c) Where did injury occur? 6/13/44 (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? on Highway 61 at Sikeston, Mo. (Specify type of place)
While at work? No (e) Means of injury: Hit by truck.

23. Signature: E. D. Urban (M. D. or other) M.D.
Address: Sikeston, Mo. Date signed 6-22-44

1318 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 844-1105
Date Filed 8-10-44

**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 Not Embalmed, Registered Apprentice No. ....., working under my personal supervision.

Signed Hunter Albritton

Licensed Embalmer No. 4210

P. O. Address Sikeston 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 this body is not embalmed, fact should be so stated above.**