FILED JAN 12 1945

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

44458

Do not use this space.

1. PLACE OF DEATH
(a) County Lawrence — Registration District No. 176
(b) Township Lincoln — Primary Registration District No. 5630 — Registered No. 31
(c) City Miller — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME George Smith Cullen
(a) Residence, No. Mt. Vernon R.R. # St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male — 4. COLOR OR RACE white — 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF ~~(OR) WIFE OF~~ Beatrice Mae Cullen

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 16 1885

7. AGE — YEARS 59 — MONTHS 5 — DAYS 8 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

FATHER
13. NAME Perry Cullen
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER
15. MAIDEN NAME Lydia A. Smith
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison Co. Indiana

17. INFORMANT (ADDRESS) Beatrice Cullen Miller Mo.

18. ~~BURIAL, CREMATION, OR~~ REMOVAL
~~FROM~~ Summit Ville Ind. DATE 10-26- 1944

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Morris-Leiman Miller Mo.

20. FILED 11-20 1944 Anna Whorry
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-25- 1944

22. I HEREBY CERTIFY, That I ~~attended deceased from~~ Was not in attendance, 19..., to ~~until~~ 10/25/44, 19..... I last saw her alive on 10/25/44, 19..... Death is said to have occurred on the date stated above, at 3:45 p.m.
The principal cause of death and related causes of importance were as follows:

Hypertrophy of the Heart — Date of onset

12 hrs

Other contributory causes of importance:
Pulmonary Tuberculosis

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) H. E. Sanders, M.D.
(Address) Miller Mo

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING [redacted] THIS IS A PERMANENT RECORD

RECEIVED
District Health Officer No. 6,
District File Number 145-13
Date Filed JAN 9 1945

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed L. R. Lemon

Licensed Embalmer No. 0297

P. O. Address Miller 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, above space should be left blank.