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#30539

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

39482

State File No.

FILED DEC 21 1945

Registration District No. 318

Primary Registration District No.

100.-

Registrar's No. 10645

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

1. **PLACE OF DEATH:**

(a) County: St. Louis, Missouri

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 22 days (Specify whether years, months or days)

In this community:

2. **USUAL RESIDENCE OF DECEASED:** 999

(a) State: Arkansas (b) County: Greene

(c) City or town: Paragould 2 (If outside city or town limits, write "RURAL") NR

(d) Street No.: (If rural, give location)

(e) Citizen of foreign country? 2 (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: Amanda Mc Culloch

3. (b) If veteran, name war: Nil

3. (c) Social Security No.: None

4. Sex: Female 1

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widow 2

6. (b) Name of husband or wife: John McCulloch

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

7. Birth date of deceased: June (Month) 11 (Day) 1867 (Year)

8. AGE:

Years	Months	Days	If less than one day
78	5	26	hr. min.

9. Birthplace: Paragould (City, town, or county) Arkansas (State or foreign country) 1

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Jim Thompson

13. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country) 9

MOTHER

14. Maiden name: Virginia Miller

15. Birthplace: Unknown (City, town, or county) Virginia (State or foreign country) 1

16. (a) Informant: Virginia Webster

(b) Address: 4105 West Pine Blvd.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12-7-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Paragould, Arkansas

18. (a) Signature of funeral director: Albert H. Hoppe

(b) Address: 4700 Washington Blvd.

19. (a) DEC 7 1945 (Date received local registrar) (b) J. T. Bradeak (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec. day: 7th year: 1945 hour: 3:40 minute: A M.

21. I hereby certify that I attended the deceased from 11/15/45, 19..., to 12/7/45, 19...; that I last saw her alive on 12/7/45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	
Due to: Cardiac Decompensation	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Senile Psychosis	
Major findings: Of operations:	
Of autopsy: Not done	

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):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? Means of injury:

23. Signature: R. L. Stubblefield (M. D. or [redacted])

Address: 1515 Lafayette Date signed: 12-7-45

(Licensed Embalmer's Statement on Reverse Side)

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 Henry M. Brammer

Licensed Embalmer No. 4200

P. O. Address.....

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.