

**FILED APR 10 1947**  
Registration District No. **239**

Primary Registration District No. **5825**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important.

**1. PLACE OF DEATH:**  
 (a) County **New Madrid Co.**  
 (b) City or town **Catron MO. (Comstadt)**  
 (c) Name of hospital or institution: **1**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_ years, months or days

**3. (a) PRINT FULL NAME** **Junior Culps.**  
**8. (b) If veteran,** name war \_\_\_\_\_ **8. (c) Social Security** No. \_\_\_\_\_

**4. Sex** **Male** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Single**  
**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband or wife if** **1944** **years**  
**7. Birth date of deceased** **March 14.** **1944**  
 (Month) (Day) (Year)

**8. AGE:** Years **2** Months **11** Days **18** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace** **Benton Ky** **1**  
 (City, town, or county) (State or foreign country)

**10. Usual occupation** **Child**

**11. Industry or business** \_\_\_\_\_

**MOTHER FATHER**  
**12. Name** **Johnie Culps,**  
**13. Birthplace** **Benton Ky.** **1**  
 (City, town, or county) (State or foreign country)  
**14. Maiden name** **Unknown**  
**15. Birthplace** **Unknown**  
 (City, town, or county) (State or foreign country)  
**16. (a) Informant's own signature** **Raymon Ashley**

**(b) Address** **Catron,**

**17. (a) Burial** **(b) Date thereof** **March, 3, 47**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** **Benton, Ky.**  
**Watkins Funeral Ser**

**18. (a) Signature of funeral director.** \_\_\_\_\_ **(b) Address** **Parma, Mo.**

**19. (a) 3-3/47** **(b) Dr. Crested**  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Missouri** (b) County **New Madrid**  
 (c) City or town **Catron,**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**20. DATE OF DEATH:** Month **March** day **2**  
 year **1947** hour **11** minute **30** A. M.

**21. I hereby certify that I attended the deceased from** **2-28-47** **to** **3-2-47**, 19\_\_\_\_;  
 that I last saw him alive on **2-1-47**, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

**Immediate cause of death** \_\_\_\_\_ **Duration** \_\_\_\_\_  
**Due to** \_\_\_\_\_  
**Due to** \_\_\_\_\_

**Other conditions** \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
**Major findings:** \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

**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? \_\_\_\_\_

**While at work?** \_\_\_\_\_ **(Specify type of place)** \_\_\_\_\_ **(e) Means of injury** \_\_\_\_\_  
**23. Signature** \_\_\_\_\_ **(M. D. or other)** \_\_\_\_\_  
**Address** \_\_\_\_\_ **Date signed** \_\_\_\_\_

**ADDITIONAL PHYSICIAN**  
**UNDERLINE THE CAUSE TO WHICH DEATH SHOULD BE CHARGED STATISTICALLY.**

RECEIVED

District Health Office No. 2

District File Number 447-491

Date Recd 4-8-47

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**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.....

Licensed Embalmer No.....

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, above space should be left blank.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
89  
Registrar's No. 89

Registration District No. 239

Primary Registration District No. 2825

1. PLACE OF DEATH:

(a) County new madrid  
(b) City or town cation  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME

Junior Culp

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 \_\_\_\_\_

7. Birth date of deceased

March 14  
(Month) (Day) (Year)

8. AGE:

Years 2 Months 11 Days \_\_\_\_\_  
(If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_)

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_

Year 1947 hour \_\_\_\_\_ minute 30 A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_

to \_\_\_\_\_, 19\_\_\_\_

that I last saw him alive on 3-2-47, 19\_\_\_\_

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions

(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) \_\_\_\_\_
- (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? \_\_\_\_\_

While at work? \_\_\_\_\_

(Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_

(M. D. or other) Geo

Address \_\_\_\_\_

Date signed \_\_\_\_\_

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

SUPPLEMENTAL

10106

Parma, MD

H. H. Alden