

National Office of Vital Statistics
FILED JUL 27 1948

Registration District No. 367

Primary Registration District No. 4547 4537

Registrar's No.

1. PLACE OF DEATH:

(a) County WASHINGTON
 (b) City or town IRONDALE
 (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 NONE
 (Specify whether years, months or days) 10.40

3. (a) PRINT FULL NAME LAWRENCE FRANCIS McCULLOUGH3. (b) If veteran, name war NONE 3. (c) Social Security No. 490-01-1219

4. Sex MALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband's wife LAVERNE
 6. (c) Age of husband or wife if alive 56 years
 7. Birth date of deceased AUGUST 16 1890
 (Month) (Day) (Year)

8. AGE: Years 57 Months 10 Days 5
 If less than one day hr. min.

9. Birthplace HAGAMAN ILLINOIS
(City, town, or county) (State or foreign country)10. Usual occupation MACHINIST11. Industry or business GARAGE12. Name WILLIAM H. McCULLOUGH13. Birthplace HAGAMAN ILLINOIS
(City, town, or county) (State or foreign country)14. Maiden name ROSE MUSGROVE15. Birthplace CARROLLTON ILLINOIS
(City, town, or county) (State or foreign country)16. (a) Informant LAVERNE McCULLOUGH(b) Address IRONDALE MO.17. (a) BURIAL (b) Date thereof 6/24/48
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation BIG RIVER IRONDALE18. (a) Signature of funeral director Bert E. Boyd(b) Address LEADWOOD MISSOURI19. (a) 7-10-48 (b) Jessie Schaefer
(Date received local registrar) (Registrar's signature)20. Signature W. H. Hoffmann M. D. or MDAddress Wasserman Date signed 6-23-4821. I hereby certify that I attended the deceased from June 1st
death 1948 to at the time
that I last saw him alive on at this time 1948
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral Hemorrhage
arterio SclerosisDue to arterio SclerosisDue to arterio SclerosisOther conditions (Include pregnancy within 3 months of death) gzwMajor findings: Of operations gzwOf autopsy gzw

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County WASHINGTON
 (c) City or town IRONDALE 110
 (If outside city or town limits, write "RURAL") 0
 (d) Street No. NONE 0
 (If rural, give location) 0
 (e) Citizen of foreign country? NO (Yes or No) 0
 If yes, name country NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21
year 1948 hour 10 minute A M.21. I hereby certify that I attended the deceased from June 1st
death 1948 to at the time
that I last saw him alive on at this time 1948
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral Hemorrhagearterio SclerosisDue to arterio SclerosisDue to arterio SclerosisOther conditions (Include pregnancy within 3 months of death) gzwMajor findings: Of operations gzwOf autopsy gzw

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 W. H. Hoffmann M. D. or MDAddress Wasserman Date signed 6-23-48

24. Signature _____

Address _____ Date signed _____

25. Signature _____

Address _____ Date signed _____

26. Signature _____

Address _____ Date signed _____

27. Signature _____

Address _____ Date signed _____

28. Signature _____

Address _____ Date signed _____

29. Signature _____

Address _____ Date signed _____

30. Signature _____

Address _____ Date signed _____

RECEIVED

District Health Officer No. 4
District File Number 748-90
Date Filed 7-24-4

WOW

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

Bert L. Boyer

Licensed Embalmer No. 3445

P. O. Address Leadwood 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.

Registration District No. 367

Primary Registration District No. 4537

1. PLACE OF DEATH:
(a) County Washington
(b) City or town Grandale
(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 _____ (Specify whether _____)
years, months or days)

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 _____

3. (a) PRINT FULL NAME Lawrence J. McCullough
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1948 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced n
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

Duration _____
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

7. Birth date of deceased Aug 16
(Month) (Day) (Year)
8. AGE: Years _____ Months _____ 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 _____
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)

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) (c) Means of injury _____

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

19. (a) 7-10-1948 (b) Messie Eichenberger
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

SUPPLEMENTARY

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

S-25282