

FILED SEP 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29950

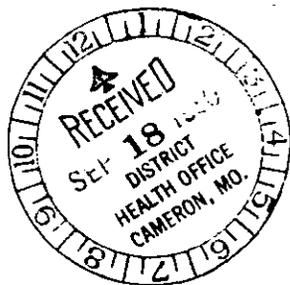
State File No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <u>494</u>		Registrar's No. <u>149</u>		
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
a. COUNTY <u>Gentry</u>		b. CITY (If outside corporate limits, write RURAL and give township) <u>Albany</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>Gentry</u>		
c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>Albany</u>		d. STREET ADDRESS _____		(If rural, give location) _____		
d. FULL NAME OF HOSPITAL OR INSTITUTION _____								
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. AGE (In years last birthday)		
a. (First) <u>Homer Hampton</u>			b. (Middle) <u>McCullough</u>			c. (Last) _____		
4. DATE OF DEATH (Month) (Day) (Year) <u>9 13 1950</u>			5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	
8. DATE OF BIRTH <u>Jan. 16, 1896</u>		9. AGE (In years last birthday) <u>54</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dentist</u>		11. BIRTHPLACE (State or foreign country) <u>Mo.</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>Joseph L. McCullough</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Crow</u>		14. NAME OF HUSBAND OR WIFE <u>Ruth Bratches McCullough</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Ruth McCullough</u>		ADDRESS <u>Albany</u>		
18. CAUSE OF DEATH				MEDICAL CERTIFICATION				
Enter only one cause per line for (a), (b), and (c)				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Mural Thrombosis</u>				
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES				
				Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				
				DUE TO (b) <u>Coronary occlusion</u>				
				DUE TO (c) <u>Myocarditis</u>				
				II. OTHER SIGNIFICANT CONDITIONS				
				Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION _____				
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>				
				<u>2 years</u>				
				<u>10 years</u>				
				<u>1-20</u>				
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION _____				
				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____		21d. (COUNTY) _____		
21e. (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____		
22. I hereby certify that I attended the deceased from <u>Jan</u> , 1940, to <u>9-13</u> , 1950, that I last saw the deceased alive on <u>9-13</u> , 1950, and that death occurred at <u>11:30 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Frank H. Ross, M.D.C.</u>			23b. ADDRESS <u>Albany, Mo.</u>			23c. DATE SIGNED <u>9-14-50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 16, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cem.</u>		24d. LOCATION (City, town, or county) <u>Albany, Mo.</u>		
24e. (State) _____		DATE REC'D BY LOCAL REG. <u>Sept 15-50</u>		REGISTRAR'S SIGNATURE <u>Edith Lehelder</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Clifford Bush</u>		
		ADDRESS <u>Albany Mo</u>						

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

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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 me

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Clifford B. Cook

Licensed Embalmer No. 3329

P. O. Address Albany 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.