

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8027**

No. 300
10.48

2270

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

FILED MAR 23 1954 REG. DIST. NO. 65 PRIMARY REG. DIST. NO. 4114 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY Chariton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Chariton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mendon		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mendon 0210	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 0	
3. NAME OF DECEASED a. (First) Brenda b. (Middle) ANN c. (Last) Cullen			4. DATE OF DEATH (Month) (Day) (Year) July 24-1954
5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH July 15-1940
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School work	11. BIRTH PLACE (State or foreign country) Mendon Mo
13a. FATHER'S NAME Mart B. Cullen		13b. MOTHER'S MAIDEN NAME Beta Pittnell	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y, N, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME, ADDRESS Mart B. Cullen Mendon Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ADRENAL NEUROBLASTOMA & MULTIPLE METASTASES ANTECEDENT CAUSES MULTIPLE METASTASES DUE TO (b) _____ DUE TO (c) _____ 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 195X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 11-27-54 , 19 54 , to 2-24 , 19 54 , that I last saw the deceased alive on 2-1 , 19 54 , and that death occurred at 11:00 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE Paul T. Berry MD (Degree or title)		23b. ADDRESS Marceline Mo.	23c. DATE SIGNED 2-26-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-27-54	24c. NAME OF CEMETERY OR CREMATORY St. Joseph	24d. LOCATION (City, town, or county) (State) East Mendon Mo
DATE REC'D BY LOCAL REG. 2-27-54	REGISTRAR'S SIGNATURE Mildred Brown	25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS S. D. Lipsard Mendon Mo	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

L. L. Lipard

Licensed Embalmer No. *3970*

P. O. Address *Mendon MA*

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.