

FILED JUL 1-9 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22621

BIRTH NO. _____ REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 3127 Registrar's No. 96

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Webb City		c. CITY OR TOWN Webb City	d. Is residence within limits of a city as incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 14 Yrs.		e. STREET ADDRESS (If rural, give location) 820 S. Madison St.	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Jane Chinn Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) M c. (Last) McCullough			4. DATE OF DEATH July 11, 1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 1, 1880	9. AGE (In years last birthday) 75	if UNDER 1 YEAR Months 4 Days 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired plumber		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Ft. Scott, Kansas		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Joseph McCullough		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE Neva M. McCullough	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Neva M. McCullough ADDRESS 820 S. Madison Webb City, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sepsis			INTERVAL BETWEEN ONSET AND DEATH 3 days
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bronchostenosis with Perforations Bronchiectasis & Bronchopneumonia DUE TO (c) Bronchogenic Stenoma			6 months
		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 162x			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) (Min)		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 6-30, 1955, to July 11, 1955, that I last saw the deceased alive on July 11, 1955, and that death occurred at 11:55 P.M., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i> (Degree or title) D.O.		23b. ADDRESS Webb City, Mo.		23c. DATE SIGNED 7-13-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-14-55		24c. NAME OF CEMETERY OR CREMATORY Carterville Cemetery	
				24d. LOCATION (City, town, or county) (State) Carterville, Mo.	

DATE REC'D BY LOCAL REG. 7-14-55		REGISTRAR'S SIGNATURE <i>[Signature]</i>		FUNERAL DIRECTOR'S SIGNATURE Johnston-Arnice-Simpson ADDRESS Webb City Mo.	
				Mortuary	

(Licensed Emballer's Statement on Reverse Side)

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

County File Number
Date Filed
JUL 18 1956

JUN 12 1956

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.....
Signature of Student Embalmer

Signed *Harvey E. Arnee*

Licensed Embalmer No. *44*

P. O. Address *Well City*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.