

securing the medical certification in the specific manner required by 193.140 MO. STAT. 1949.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All  
 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14368

FILED APR 29 1957

STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Osceola</u> <u>0930</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Todd's Hospital</u>		Length of stay in lb <u>5 days</u>	d. STREET ADDRESS (If outside, give location) <u>Waites Rest Home</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Robert</u> <sup>First</sup> <u>E. Culbertson</u> <sup>Middle</sup> <u></u> <sup>Last</sup>			4. DATE OF DEATH Month <u>April</u> , Day <u>16</u> , Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan; 17, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>84</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (City and state or country) <u>Austin Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John M. Culbertson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret A. Culbertson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Fred Langdon, Collins Missouri</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>embolism</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>  <u>2 days</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>4201</u>	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION <u>Osceola, Mo.</u>		COUNTY _____ STATE _____	
21. I attended the deceased from <u>April 14, 1957</u> to <u>April 16, 1957</u> and last saw <del>him</del> <sup>XXXX</sup> alive on <u>4-16-57</u> Death occurred at <u>10:40 P. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. L. Shipman, D.O.</u>		22b. ADDRESS <u>Osceola, Mo.</u>	
22c. DATE SIGNED <u>4-17-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/20/57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Allen</u>		23d. LOCATION (City, town, or county) (State) <u>Collins Mo.</u>	
24. FUNERAL DIRECTOR <u>H. L. Shipman Osceola Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-22-57</u>	
26. REGISTRAR'S SIGNATURE <u>Patk Seavers</u>			

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 .....

Licensed Embalmer No. 399

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