

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031423

STATE FILE NUMBER

FILED SEP 8 1958

Registration District No. 324 Primary Registration District No. 30720 Registrar's No. 140

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| 1. PLACE OF DEATH a. COUNTY <u>Saline</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Marshall</u> TOWN | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Marshall 0972</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>585 W. Arrow</u> | | Length of stay in 1b <u>4 yrs</u> | d. STREET ADDRESS (If outside, give location) <u>585 W. Arrow</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|----------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>CULPERNA</u> Last <u>JOHNS</u> | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>1</u> Year <u>1958</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 7, 1877</u> | 9. AGE (In years last birthday) <u>81</u> IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | 11. BIRTHPLACE (City and state or country) <u>Osage County, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |
| 13. FATHER'S NAME <u>John A. Wright</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary Agee</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>Mrs Jasper Efferson</u> Address <u>Marshall Mo</u> | | |

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| 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>Cerebral Vas Accident</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Thrombosis.</u> | | |
| DUE TO (c) _____ | | <u>7 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332X</u> | | |

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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.) |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ | |

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|--|---|--|-----------------------------------|
| 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>Marshall, Mo.</u> | COUNTY _____ STATE _____ |
| 21. I attended the deceased from <u>9-1-58</u> , to <u>9-2-58</u> and last saw her ^{her} alive on <u>9-1-58</u> . Death occurred at <u>1:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Type or print) <u>B. H. Kimpsheld M.D.</u> | | 22b. ADDRESS <u>Marshall, Mo.</u> | 22c. DATE SIGNED <u>9-2-58</u> |

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|--|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>9-3-1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Miami Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Miami Mo</u> |
| 24. FUNERAL DIRECTOR <u>Harry Horshberger</u> Address <u>Marshall, Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>9-2-58</u> | 26. REGISTRAR'S SIGNATURE <u>Carl G. Read</u> |

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service

300 1-56

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

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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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Harry Hersherberg*

Licensed Embalmer No. *43*

P. O. Address *Marshall*

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.