

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039893
STATE FILE NUMBER

FILED NOV 24 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5358

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A HOSPITAL		Length of stay in lb 65 years	
d. STREET ADDRESS 2023 EAST 48TH TERR		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RALPH LOREN CULVER			4. DATE OF DEATH Month Day Year November 10, 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1891
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		9b. KIND OF BUSINESS OR INDUSTRY Farming	9c. BIRTHPLACE (City and state or country) Bates, Colorado
10a. FATHER'S NAME Charles Culver		10b. MOTHER'S MAIDEN NAME Minnie Florence Stephenson	12. CITIZEN OF WHAT COUNTRY? U.S.A.
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 500 40 8320	17. INFORMANT VA Hospital Official Records, K. C. Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) _____ DUE TO (c) Multiple myeloma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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.) 2034	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from January 2, 1957 to November 10, 1958 Death occurred at 11:05 AM on the date stated above; and to the best of my knowledge, from the causes stated.		21b. ADDRESS VA Hospital, K. C. Mo.	
22a. SIGNATURE J. A. Turner (Degree or title) M.D.		22c. DATE SIGNED 11-11-58	
23a. BURYAL CREMATION, (Specify) Burial		23b. DATE 11-13-58	
23c. NAME OF CEMETERY OR CREMATORY Appleton City Cem.		23d. LOCATION (City, town, or county) (State) Appleton City Mo.	
24. FUNERAL DIRECTOR Wagner Funeral Home, K C Mo		25. DATE RECD. BY LOCAL REG. 11-12-58	
26. REGISTRAR'S SIGNATURE Neva Trunshall			

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



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 *Thomas O. Kaeller*

Licensed Embalmer No. *4895*

P. O. Address *H. E. Moore*

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.