

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035808

FILED VS OCT 26 1959

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2570 Registrar's No. 1102

ENDED

| | | | | | |
|---|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Greene | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howell | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield | | Length of stay in 1b 1 day | c. CITY OR TOWN Willow Springs | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Park Ave. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last BERTHA CULBERTSON | | | 4. DATE OF DEATH Month Day Year October 15, 1959 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 28, 1895 | 9. AGE (last birthday) 64 | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY In Home | 11. BIRTHPLACE (City and state or country) Howell County, Mo. | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE John W. Culbertson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address William Barnes Willow Springs, 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) Burns, flesh, 75% of body surface 12. hrs. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertensive cardiovascular renal disease | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input checked="" 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.) Granite stone explosion at home | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 10 | Month, Day, Year 10/14/59 | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | 20f. CITY, TOWN, OR LOCATION Willow Springs, Howell, Mo. | COUNTY | STATE | |
| 21. I attended the deceased from 1:30 PM to 2 A.M. and last saw him alive on 11:30 PM, 10/14/59 Death occurred at 2 A. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Robert W. Baker M.D. | | | 22b. ADDRESS Prof. Bldg. Springfield, Mo Oct 17, 1959 | | 22c. DATE SIGNED |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Oct. 16, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Lone Camp | 24. LOCATION (City, town, or county) (State) Willow Springs, Missouri | | |
| 24. FUNERAL DIRECTOR ADDRESS Burns Funeral Home Willow Springs, Missouri | | 25. DATE RECD. BY LOCAL REG. 10-19-59 | 26. REGISTRAR'S SIGNATURE Effie S. Melton | | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Lewis G. Harkopf

Licensed Embalmer No. 3802

P. O. Address Springfield

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.