RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-048921

STATE FILE NUMBER

LED VS JAN 23 1961 333

Registration District No. _____ Primary Registration District No. 3074 Registrar's No. 6

1. PLACE OF DEATH
a. COUNTY Scott
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston — Length of stay in Ib 1 day
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Delta Comm. Hospital — Inside Limits Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Scott
c. CITY OR TOWN Sikeston — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 367 North Kingshighway — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First EMMA Middle LOUISE Last CULP
4. DATE OF DEATH: Month 12 Day 31 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed X Divorced ☐
8. DATE OF BIRTH: 3/14/1894
9. AGE (last birthday): 66 — IF UNDER 1 YEAR: Months 9 Days 17 — IF UNDER 24 HR: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (City and state or country): Lincoln, Illinois
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Chris. F. Jens
13b. MOTHER'S MAIDEN NAME: Caroline Holtz
14. NAME OF HUSBAND OR WIFE: Hollis Culp (Dec)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 492-18-0993
17. INFORMANT: Caroline Edwards, Address: Chaffee, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident -
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) A C V Disease
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)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes X No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO X
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12-29-60, to 12-31-60 and last saw her/him alive on 12-31-60
Death occurred at 6:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Alden B. Sargent M.D. (Degree or title)
22b. ADDRESS Sikeston, Mo.
22c. DATE SIGNED 1-2-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE 1/3/61
23c. NAME OF CEMETERY OR CREMATORY: Garden Of Memories
23d. LOCATION (City, town, or county) (State): Sikeston, Mo.

24. FUNERAL DIRECTOR: Albritton Funeral Home, ADDRESS: Sikeston, Mo.
25. DATE RECD. BY LOCAL REG.: 1-9-61
26. REGISTRAR'S SIGNATURE: Mrs Ella Hunter

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Raymond L. Du

Signature of Student Embalmer

Licensed Embalmer No. 4798

P. O. Address Bernie

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c 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.