

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-033467

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 126

FILED SEP 12 1962

DO NOT WRITE ON THIS STUB

AMENDED

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Vernon | | 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 Nevada | | Length of stay in 1b 4 yr. 10 mo. 8 da. | c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 3 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1501 Admiral Blvd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Helen Middle Louise Last Kulp | | | 4. DATE OF DEATH Month Aug. Day 26 Year 1962 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1-29-08 |
| 9. AGE (last birthday) 54 | | IF UNDER 1 YEAR Months - Days - | IF UNDER 24 HR Hours - Min. - |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) Springfield, Missouri |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME G. Muhr | |
| 13b. MOTHER'S MAIDEN NAME Mabel Smallet | | 14. NAME OF HUSBAND OR WIFE Charles W. Kulp | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) - | | 16. SOCIAL SECURITY NO. -- | 17. INFORMANT Address Hosp. records, State Hosp. #3, Nevada, 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) Coronary Occlusion | | | INTERVAL BETWEEN ONSET AND DEATH few minutes |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Brain Syndrome Associated with Central Nervous System Syphilis (Meningoencephalitis) and Other Central Nervous System Syphilis with | | | years |
| DUE TO (c) Psychotic Reaction. | | | " |
| 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. <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 type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> None | 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 <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.) None | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. Attended the deceased from (VIEWED) THE BODY and last saw him alive on 8-26-62 Death occurred at 8:10 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Hilda Mungis M.D. | | 22b. ADDRESS STATE HOSP. NEVADA, MO | 22c. DATE SIGNED 8-26-62 |
| 23a. DONOR ORGANIZATION, REMOVAL (Specify) | 23b. DATE Aug 30 | 23c. NAME OF CEMETERY OR CREMATORY NATIONAL | 23d. LOCATION (City, town, or county) (State) LAVANWORTH, Kan. |
| 24. FUNERAL DIRECTOR Melody McGilley | | ADDRESS K.C. Mo. | 25. DATE RECD. BY LOCAL REG. 9-8-1962 |
| 26. REGISTRAR'S SIGNATURE Anna E. Perry | | | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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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  _____

Licensed Embalmer No. 4853

P. O. Address Florida, Mo.

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.