

FILED MAR 3 1945

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Boone County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 Days (Specify whether  
In this community 50 Years (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME JESSE BIRD McCOLLY

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male (M) 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 11 - 30 - 1874  
(Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 9 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Paris Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer & Carpenter

11. Industry or business \_\_\_\_\_

12. Name Andrew J. McColly

13. Birthplace Pittsburgh Pennsylvania  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Gibbins

15. Birthplace Louisville Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. E.O. Pickett

(b) Address 7 Ripley St., Columbia, Mo.

17. (a) Burial (b) Date thereof 1-11-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Zion Cemetery

18. (a) Signature of funeral director Parson Funeral Service  
Columbia, Mo.

(b) Address \_\_\_\_\_

19. (a) 1-11-1945 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone  
(c) City or town Columbia  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7 Ripley St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes/No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 9  
year 1945 hour 11 minute 20 P.M.

21. I hereby certify that I attended the deceased from Jan. 8, 1945, to Jan 9, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Acute Uremia Duration 10 days

Due to Hypertrophy of Prostate  
Benign

Other conditions Marked Arterio Sclerosis  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 12/10

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (a) Means of injury \_\_\_\_\_

23. Signature Edwinc Schmitt (M. D. or other) \_\_\_\_\_  
Address Columbia, Mo Date signed 1/10/45

1030

WHITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2  
43  
30  
35897

RECEIVED

District Health Officer N

District File Number.....

Date Filed 3-2-43

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed M. S. Whitcomb

Licensed Embalmer No. 3893

P. O. Address. Columbia

**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 this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. March  
Registrar's No. 5

Registration District No. 38

Primary Registration District No. 3004

1. PLACE OF DEATH: Boonville  
(a) County Boonville  
(b) City or town Columbiana  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Jesse Bird McCally  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Nov 30 1905  
(Month) (Day) (Year)

8. AGE: Years 70 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 1-11-1945 (b) Edna H. Barber  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

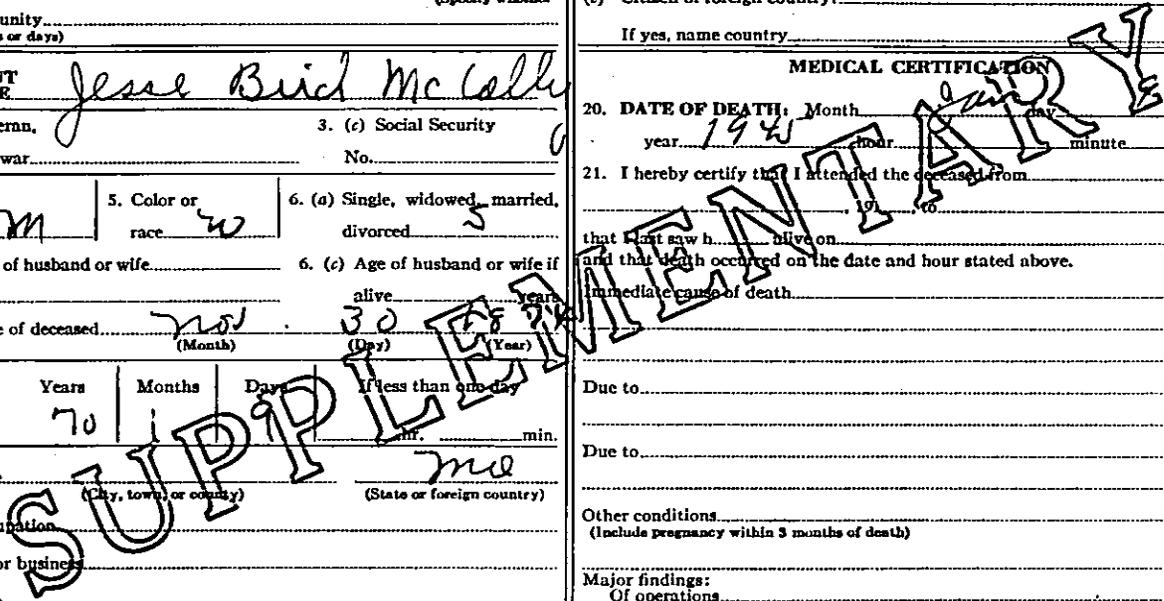
MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD



S-5533 1945