

Health, Welfare Public Service

FILED AUG 30 1957
r. Ossman

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27835

STATE FILE NUMBER

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 275

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u>		c. CITY OR TOWN <u>Jefferson City</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Home</u>		d. STREET ADDRESS (If outside, give location) <u>1201 Lee Street</u>	
Length of stay in 1b <u>50 yrs</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Ann</u> Last <u>McCully</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1957</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-8-1870</u>	9. AGE (In years last birthday) <u>87</u>	10. FUNDER 1 YEAR Months <u>8</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>College Mannd, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William G. Terry</u>	13b. MOTHER'S MAIDEN NAME <u>Bonnie White</u>	14. NAME OF HUSBAND OR WIFE <u>J.J. McCully</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Minnie Schwerdtfeger, Jeff City, Mo</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>General arteriosclerosis x senility</u>		DUE TO (c) <u>420.0</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	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.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
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21. I attended the deceased from <u>Jan 1957</u> to <u>Aug 6-57</u> and last saw her alive on <u>Aug 6-1957</u> Death occurred at <u>8:15 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>R. Ossman MD</u> (Degree or title)	22b. ADDRESS <u>Jefferson City, Mo.</u>	22c. DATE SIGNED <u>Aug. 23, 1957</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/20/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson City, Mo</u>
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24. FUNERAL DIRECTOR <u>Thorpe J Gordon, Jefferson City, Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>24 Aug 1957</u>	26. REGISTRAR'S SIGNATURE <u>R.P. Harris MD MR</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Joseph J. Jordan*

Licensed Embalmer No. *1256*
P. O. Address *Jeff City, 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).
C 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.