

FILED NOV 4 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34900  
STATE FILE NUMBER  
1173

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1173

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u> <u>0117</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Parkview N.H.</u>		d. STREET ADDRESS (If outside, give location) <u>6307 Carnegie</u>	
3. NAME OF DECEASED (Type or print) First <u>HALLIE</u> Middle <u>McCULLY</u> Last <u>McCULLY</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1957</u>	
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 19, 1888</u>
9. AGE (In years (no birthday)) <u>69</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Atchison, Kansas</u>
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>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>L.W. Joseph</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Smith</u>	14. NAME OF HUSBAND OR WIFE <u>William H. McCulley</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>491-22-6341</u>	17. INFORMANT <u>Mrs. Chas. Vulgamott-314 Ind.</u> Address <u>St. Joseph, Mo.</u>
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>Cerebral Vascular Accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) <u>Hypertension</u>			<u>5 years</u>
DUE TO (c) <u>Senility</u>			<u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>			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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <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 _____	
21. I attended the deceased from <u>10/5/1957</u> to <u>10/26/1957</u> and last saw her/him alive on <u>10/26/1957</u> Death occurred at <u>7:18 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John P. Reardon M.D.</u> (Degree or title)		22b. ADDRESS <u>6207 King Hill Ave.</u> <u>St. Joseph, Mo.</u>	
		22c. DATE SIGNED <u>10/28/57</u>	
23a. BURIAL, CREMATION, REBURYAL (Specify) <u>Burial</u>		23b. DATE <u>Oct 28, 1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sugar Creek</u>		23d. LOCATION (City, town, or county) (State) <u>Rushville Mo.</u>	
24. FUNERAL DIRECTOR <u>John E. Ruff</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 1, 1957</u>	
ADDRESS <u>6054 Pryor Ave.</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

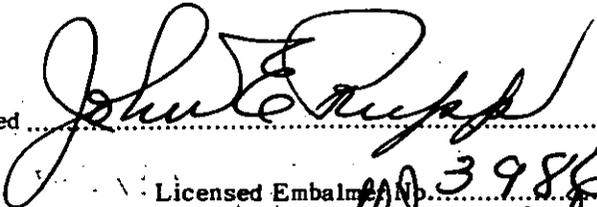
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

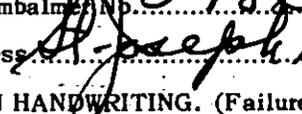
MEDICAL CERTIFICATION

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. 3986

P. O. Address .....

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.