

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-020893
STATE FILE NUMBER

FILED JUN 23 1958 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 260

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COLUMBIA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>LOUISIANA</u> 0820 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ELLIS FISCHER</u>		Length of stay in 1b <u>57 DAYS</u>	d. STREET ADDRESS (If outside, give location) Reside on, Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>PEARL</u> Middle <u>ALICE</u> Last <u>MCCARTY</u>			4. DATE OF DEATH Month <u>6</u> - Day <u>13</u> - Year <u>1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-1900</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months _____ Days _____
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	11. BIRTHPLACE (City and state or country) <u>LITCHFIELD, ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>CHARLES ROACH</u>		13b. MOTHER'S MAIDEN NAME <u>ADA ROACH</u>		14. NAME OF HUSBAND OR WIFE <u>JAMES S. MCCARTY</u>	
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. <u>-</u>	17. INFORMANT Address <u>HOSPITAL RECORDS</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>CARCINOMA OF CERVIX</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 mos.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		<u>171X</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>IRRADIATION NECROSIS of SMALL AND LARGE INTESTINE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>MARCH 15, 1958</u> to <u>JUNE 13 1958</u> and last saw her alive on <u>JUNE 13 1958</u> Death occurred at <u>4:15</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Walter J. Miller M.D.</u>	22b. ADDRESS <u>644 GEOFFARY UNIVERSITY CITY 24 MO.</u>	22c. DATE SIGNED <u>13 June 58</u>

23a. BURIAL, CREMATION, EMBOWAL (Specify) <u>BURIAL</u>	23b. DATE <u>June 16-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bowling Green, Mo.</u>	23d. LOCATION (City, town, or county) (State) <u>Bowling Green, Missouri</u>
24. FUNERAL DIRECTOR <u>John W. Miller</u> ADDRESS <u>Bowling Green, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>June 14, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>

(Licensed Embalmer's Statement on Reverse Side)

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 *John W. Butler*
Licensed Embalmer No. *4447*
Address *Rocky Green*

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.