

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028610
STATE FILE NUMBER

FILED AUG 22 1958

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 244

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> b. COUNTY <u>Montana</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Mc Girk</u> <u>6650</u>
c. FULL NAME (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Marys Hosp.</u>		Length of stay in lb <u>33 hrs.</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>RUTH</u> Last <u>OSICK</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>13</u> Year <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>Mar 12 - 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>no.</u>	11. BIRTHPLACE (City and state or country) <u>Mc Girk Mo.</u>
13a. FATHER'S NAME <u>Henry Dolstein</u>		13b. MOTHER'S MAIDEN NAME <u>Maggie Blank</u>	14. NAME OF HUSBAND OR WIFE <u>Walter Osick</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>no.</u>	17. INFORMANT Address <u>Walter Osick Mc Girk 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>Subdural Hematoma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>23 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Skull Fracture</u>			<u>33 hours</u>
DUE TO (c) _____			<u>9000</u> <u>21</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 checked="" 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.) <u>Fell on concrete steps and struck head</u>		
20c. TIME OF INJURY Hour <u>1:00</u> Month <u>8</u> Day <u>12</u> Year <u>58</u> p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. CITY, TOWN, OR LOCATION <u>Mc Girk</u>		COUNTY <u>Montana</u> STATE <u>Mo.</u>
21. I attended the deceased from <u>8-12-58</u> to <u>8-14-58</u> and last saw her alive on <u>8-12-58</u> Death occurred at <u>10:30 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Louise Gallagher MD</u>		22b. ADDRESS <u>California Mo.</u>	22c. DATE SIGNED <u>8-14-58</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>aug-15-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mc Girk City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mc Girk Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Wright E. Williams California Mo</u>		25. DATE RECD. BY LOCAL REG. <u>15 August 1958</u>	26. REGISTRAR'S SIGNATURE <u>R.P. Norris, MD-MR</u>

(Licensed Embalmer's Statement on Reverse Side)
Coff. Carr. Rec. 18 Aug 1958

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 *Hugh E. Hillman*

Licensed Embalmer No. *3537*

P. O. Address *California 7*

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.