

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016262

FILED VS MAY 9 1960

Registration District No. 261 Primary Registration District No. 3048 Registrar's No. 107

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Nodaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Maryville</b>		Length of stay in 1b <b>1 day</b>	c. CITY OR TOWN <b>International Falls</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Francis Hosp</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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 Middle Last <b>Bertha - Johnson</b>			4. DATE OF DEATH Month Day Year <b>5-3-1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-26-1903</b>	9. AGE (last birthday) <b>57</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse aid</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Nurse aid</b>	11. BIRTHPLACE (City and state of country) <b>International Falls, Minn.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Unknown</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>James C. Bergquist</b>	Address
---	---	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Transverse shock</b>	<b>1 hr. 55 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Internal injuries</b>	<b>1 hr. 55 min.</b>
	DUE TO (c) <b>Compound fracture both femurs</b>	<b>1 hr. 55 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Brain contusion</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.) <b>Car was under driving hit by truck</b>
20c. TIME OF INJURY <b>6:15 a.m.</b>	Month, Day, Year <b>5 3 60</b>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>71 1/2 south of Maryville</b>	20f. CITY, TOWN, OR LOCATION <b>Maryville</b>	COUNTY <b>Nodaway MO.</b>	STATE
21. I attended the deceased from <b>5/3/60</b> to <b>5/3/60</b> and last saw her/him alive on <b>5/3/60</b>		Death occurred at <b>9:16 A m</b> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <b>B. F. Gland M.D.</b>	22b. ADDRESS <b>Maryville MO</b>	22c. DATE SIGNED <b>5/3/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-6-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rice Hill</b>
24. FUNERAL DIRECTOR <b>Johnson Funeral Home</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>5 6 60</b>
26. REGISTRAR'S SIGNATURE <b>Bene Bold</b>		

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

JUL 29 1960

MAY 18 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by George M. Peterson Student Embalmer No. 600  
working under my personal supervision.

Student George M. Peterson Signed G. M. Peterson  
Signature of Student Embalmer

Licensed Embalmer No. 3279  
P. O. Address Maryville

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.