

WHEN THIS COPY CARRIES THE RAISED SEAL OF THE NEBRASKA STATE DEPARTMENT OF HEALTH, IT CERTIFIES THE BELOW TO BE A TRUE COPY OF AN ORIGINAL RECORD ON FILE WITH THE STATE DEPARTMENT OF HEALTH, BUREAU OF VITAL STATISTICS, WHICH IS THE LEGAL AUTHORITY FOR VITAL RECORDS.

DATE OF ISSUANCE
MAR 23 1995
LINCOLN, NEBRASKA

STANLEY S. COOPER, DIRECTOR
BUREAU OF VITAL STATISTICS

STATE OF NEBRASKA - DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. DECEDENT - NAME FIRST MIDDLE LAST DAVID BOYD McCULLEY			2. SEX MALE	3. DATE OF DEATH - Month Day Year MARCH 11, 1995	
4. CITY AND STATE OF BIRTH (if not in U.S. name country) INDIANOLA IOWA		5a. AGE - Last Birthday 70s 86	5b. UNDER 1 YEAR MONTHS DAYS 86	5c. UNDER 1 DAY HOURS MINUTES 86	6. DATE OF BIRTH - Month Day Year NOVEMBER 28, 1908
7. SOCIAL SECURITY NUMBER 505-40-0897			8a. PLACE OF DEATH HOSPITAL <input type="checkbox"/> Private <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> ER Outpatient <input checked="" type="checkbox"/> Respite <input type="checkbox"/> DCA <input type="checkbox"/> Other <input type="checkbox"/>		
8b. FACILITY - Name (if not institution, give street and number) Westview Retirement Community			8c. CITY TOWN OR LOCATION OF DEATH GRANT		
9a. RESIDENCE - STATE NEBRASKA		9b. COUNTY PERKINS	9c. CITY, TOWN OR LOCATION GRANT	9d. STREET AND NUMBER (including 2d. Class) Rt. 1 Box 21 (69140)	9e. INSIDE CITY LIMITS Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
10. RACE - (eg. White, Black, American Indian, etc.) (Specify) WHITE	11. ANCESTRY (eg. Irish, Mexican, German, etc.) IRISH-AMERICAN	12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	13. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	13. NAME OF SPOUSE (if one give maiden name) NONE	
14a. USUAL OCCUPATION (Give kind of work done during most of working life - even if retired) SCHOOL TEACHER		14b. KIND OF BUSINESS INDUSTRY SECONDARY EDUCATION		15. EDUCATION (Specify if - highest grade completed) Elementary or Secondary <input type="checkbox"/> College 11, 12 or 13 <input checked="" type="checkbox"/> College 14 or 15 <input type="checkbox"/>	
16. FATHER - NAME FIRST MIDDLE LAST BOYD McCULLEY		17. MOTHER - FIRST MIDDLE MAIDEN SURNAME LEILA WEEDE			
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year and dates of service) NO			19a. INFORMANT - NAME CAROLYN McARTOR		
19b. INFORMANT MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) 11CR 80-Box 4 - GRANT NEBR. 69140					
20. EMPLOYER'S SIGNATURE LICENSE NO. John Long 901		21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Removal <input type="checkbox"/>	21b. DATE MARCH 14, 1995	21c. CEMETERY OR CREMATORY NAME FAIRVIEW CEMETERY	
22a. HOME PHONE - NAME BULLOCK-LONG		22b. CEMETERY OR CREMATORY LOCATION CITY OR TOWN STATE GRANT NEBRASKA		22c. FUNERAL HOME ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) Box 452 - GRANT NEBR. 69140	
23. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR 1a, 1b AND 1c) PART I 1a. acute myocardial infarction Interval between onset and death 1b. immediate Interval between onset and death 1c. immediate Interval between onset and death					
24. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not reported PART II 24a. ACCIDENT <input type="checkbox"/> Unintentional <input type="checkbox"/> 24b. SUICIDE <input type="checkbox"/> Pending <input type="checkbox"/> 24c. HOMICIDE <input type="checkbox"/> Investigation <input type="checkbox"/>					
25a. DATE OF INJURY (Mo. Day Yr) MARCH 11, 1995		25b. HOUR OF INJURY 6:00 A.M.	25c. DESCRIBE HOW INJURY OCCURRED NO		
26a. INJURY AT WORK Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		26b. PLACE OF INJURY - (If home, farm, street, factory, place building, etc. (Specify)) NO		26c. LOCATION STREET OR R.F.D. NO. CITY OR TOWN STATE NO	
27a. DATE OF DEATH (Mo. Day Yr) MARCH 11, 1995		27b. DATE SIGNED (Mo. Day Yr) 3/17/95		27c. TIME OF DEATH 6:00 A.M.	
27d. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) Clifford Colglazier M.D.		27e. On the basis of examination and investigation, it is my opinion death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) Clifford Colglazier M.D.		27f. On the basis of examination and investigation, it is my opinion death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) Clifford Colglazier M.D.	
28. DID TOBACCO USE CONTRIBUTE TO THE DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		29. HAD ORGAN OR TISSUE DONATION BEEN CONSIDERED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		30. WAS CONSENT OBTAINED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
31. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, CORONER'S PHYSICIAN OR COUNTY ATTORNEY) (If not at home) CLIFFORD COLGLAZIER, M.D. - GRANT NEBR. 69140					

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BOOK 43 PAGE 442
96 MAY -2 PM 2:43
MICHELLE UTSLER
RECORDER
MADISON COUNTY, IOWA

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REC \$ 5.00
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