MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32063

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH
County: Vernon
Township:
City: Nevada (No. ... St. ... Ward)
Registration District No. 875
Primary Registration District No. 3039
File No.
Registered No. 210

2. FULL NAME Dr Laskin H. Callaway

(a) Residence. No. 526 W. Oak St., 4 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Lou. Callaway

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 6-23-1855

7. AGE: Years 70 | Months 3 | Days 8 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): "
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN): Nevada Mo
(STATE OR COUNTRY): Mo

PARENTS
10. NAME OF FATHER: Dr Callaway
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Kentucky
(STATE OR COUNTRY):
12. MAIDEN NAME OF MOTHER: Letitia Logan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Kentucky
(STATE OR COUNTRY):

14. INFORMANT: David Callaway
(Address): Nevada Mo

15. FILED: Oct 3, 1925 C R King, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct. 1, 1925

17. I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1925, to Oct. 1, 1925, that I last saw alive on Oct. 1, 1925, and that death occurred, on the date stated above, at 4:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral hemorrhage
(duration) ... yrs. ... mos. 6 ds

CONTRIBUTORY (SECONDARY): Arteriosclerosis
(duration) ... yrs. ... mos. ... ds

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) C R King, M. D
Oct 3, 1925 (Address) Nevada Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Greenwood Cemetery | DATE OF BURIAL: Oct. 3 1925
20. UNDERTAKER: W. Thornsbert | ADDRESS: Nevada

Dr King

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....,..... St. .....

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....

(Usual place of abode) ..... (If nonresident give city or town an

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....

(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....

(STATE OR COUNTRY)

14.

INFORMANT .....

(Address)

15.

FILED....., 19..... .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.

I HEREBY CERTIFY, That I attended deceased fro

.....,19.....; to .....

that I last saw h..... alive on....., 1

death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLE (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENT HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DAT

20. UNDERTAKER | ADD