

OCT 30 1930

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

Do not use this space.

30436

1. PLACE OF DEATH

County Linn
Township _____
City Laclede (No. _____)

Registration District No. 500
Primary Registration District No. 4803

File No. _____
Registered No. 8
St. _____ Ward _____

2. FULL NAME

Unmarried - McCallum
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept. 15 - 1930</u>		
7. AGE	YEARS	MONTHS
		DAYS
		3
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) Laclede
(STATE OR COUNTRY) Mo

PARENTS	10. NAME OF FATHER <u>Unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
	12. MAIDEN NAME OF MOTHER <u>Alma L. McCallum</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Linn Co. Mo.</u>

14. INFORMANT G. L. McCallum
(Address) Laclede Mo.

15. FILED 9/19, 1930 J. M. Burke
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 18 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1930, to Sept 18 1930 that I last saw her alive on Sept 18 1930 and that death occurred, on the date stated above, at 8:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Temperature birth-failure
of foramen ovale to close
159C
159 (duration) 3 yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) 159C (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 _____
(Signed) G. S. McCallum, M.D.
9/18, 1930 (Address) Brunswick

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Brunswick Mo.</u>	DATE OF BURIAL <u>17/19/30 19</u>
20. UNDERTAKER _____	ADDRESS _____

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.

