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

Do not use this space.

39221

File No. ____
Registered No. 5-6

1. PLACE OF DEATH
County: Howard,
Registration District No.: 878
Township: ____
Primary Registration District No.: 4222
City: Fayette, (No. ____, ____ St. ____ Ward)

2. FULL NAME: Betty Lou Kallaras

(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. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 13th 1927

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
	3	5	9	

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) Fayette, Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Mike Kallaras,
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ____
(STATE OR COUNTRY) Greece. Greece
12. MAIDEN NAME OF MOTHER Julia Ann Shepherd
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ____
(STATE OR COUNTRY) Missouri.

14. INFORMANT Mike Kallaras.
(Address) Fayette, Mo.

15. FILED 12 30, 1930 V. O. Bonham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12 /22/30 19

17.
I HEREBY CERTIFY, That I attended deceased from Dec 22, 1930, to Dec 22, 1930 that I last saw he alive on Dec 22, 1930, and that death occurred, on the date stated above, at ____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage with Convulsions
12 hrs
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (SECONDARY) Intestinal Toxemia
(duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH ____
DID AN OPERATION PRECEDE DEATH? Spinal puncture DATE OF 12-22-30
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Spinal Puncture
(Signed) [illegible], M. D.
, 19 (Address) Fayette 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Johnson County.	12 /22/1930 19

20. UNDERTAKER	ADDRESS
Guy T. Halley.	Fayette, Mo.

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.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH
County: Howard — Registration District No.: 378 — File No.:
Township: — Primary Registration District No.: 4222 — Registered No.: 56
City: Fayette (No. , St. Ward)

2. FULL NAME: Betty Lou Kallaras

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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 12-30, 19 V. O. Bonham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-22 1930

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral hemorrhage
with convulsions
No accident
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Intestinal Typemia
(duration) yrs. mos. ds.

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) , M. D
, 19 (Address)

*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 — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

S-39221