

0830 FEB 24 1939

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

3004  
Do not use this space.

1. PLACE OF DEATH

(a) County Madison Registration District No. 2-38  
(b) Township St. Michael Primary Registration District No. 3028 Registered No. 3  
(c) City Fredricktown (d) Street No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Edw. William David Calloway  
(a) Residence, No. Fredricktown, Missouri St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Letha Ann Odem Calloway  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 13, 1869  
7. AGE YEARS 69 MONTHS 10 DAYS 1 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Musician  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Fredricktown (STATE OR COUNTRY) Missouri

FATHER 13. NAME Powell H. Calloway  
14. BIRTHPLACE (CITY OR TOWN) Not Known (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME, Unknown  
16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT Miss Martha Horica (ADDRESS) Fredricktown

18. BURIAL, CREMATION, OR REMOVAL PLACE Fredricktown DATE Jan 16 1939

19. FUNERAL DIRECTOR (NAME) Ed. H. Mott (ADDRESS) Fredricktown Mo

20. FILED Jan 16 1939 S. G. S. Langhorne Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 14, 1939  
22. I HEREBY CERTIFY That I attended deceased from Jan 13, 1938, to Jan 14, 1939  
I last saw him alive on Jan 14, 1939. Death is said to have occurred on the date stated above, at 12:15 P.M.  
The principal cause of death and related causes of importance were as follows:

Apoplexy (Third attack) Date of onset Jan 13, 1938  
Organic heart disease Unknown  
Other contributory causes of importance: \_\_\_\_\_  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_ (Signed) E. E. Hodson, M. D.  
(Address) Fredricktown, 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.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

Myron A. LaPee, or by

Registered/Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

Myron A. LaPee

Licensed Embalmer No. 4025

P. O. Address

Fredericktown Md

**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 this body is not embalmed, above space should be left blank.**