

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36617

State File No. _____

Registration District No. 533

Primary Registration District No. 3027

Registrar's No. 93

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Macon
(c) Name of hospital or institution: none
(If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether years, months or days)

In this community All of her life

3. (a) PRINT FULL NAME Callie ARISMAN

8. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ross H. Arisman 6. (c) Age of husband or wife if alive years

7. Birth date of deceased: Feb. 13 (Month) (Day) (Year) 1875

8. AGE: Years 64 Months 8 Days 10 If less than one day hr. min.

9. Birthplace Elmer Mo. (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business none

12. Name James Burns

13. Birthplace Pike Co. Mo. (City, town, or county) (State or foreign country)

14. Maiden name Mary Jane Elliott

15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant's own signature R. H. Arisman

(b) Address Macon, Mo.

17. (a) Burial (b) Date thereof 10-25-1939 (Month) (Day) (Year)

(c) Place: burial or cremation Macon, Mo. Oakwood Bur.

18. (a) Signature of funeral director Stephens Gooding

(b) Address 309 N. Ruby Macon, Mo.

19. (a) 11/8/39 (Date received local registrar) (b) Leola Hewitt (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon
(c) City or town Macon
(If outside city or town limits, write "RURAL")

(d) Street No. North Rollins
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 23 year 1939 hour 8 minute 45 a.m.

21. I hereby certify that I attended the deceased from June 10 - 1929 to Oct. 8 - 1939; that I last saw her alive on Oct. 8 - 1939; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Thrombosis of Arteria by Calvaria
phlegmon

Due to Arterio-sclerosis of coronary
arteries and Arch of Aorta

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations None

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature A L Canine (M. D. or other) _____

Address Macon Mo Date signed 11-6-39

(Licensed Embalmer's Statement on Reverse Side)

DEC 22 1944

RECEIVED

District Health Officer No. 10.

District File No. 11-39-1993

Date Filed

NOV 8 1939

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, or by

working under my personal supervision.

Signed

C. L. Stephens

Licensed Embalmer No.

3057

P. O. Address

Macon, Mo.

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.