DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 21 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3267

Registration District No. 647 Primary Registration District No. 3857 Registrar's No.

1. PLACE OF DEATH:
(a) County Ozark
(b) City or town Tecumseh (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Ozark
(c) City or town Tecumseh, (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Alvin Callicott 423
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Victoria Miller
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased Oct. (Month) 11 (Day) 1861 (Year)
8. AGE: Years 78 Months 2 Days 25 If less than one day hr. min.
9. Birthplace Ill. (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business Own Farm
MOTHER FATHER
12. Name Wade Callicott
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mary Huston
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Wade Callicott
(b) Address West Plains
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 8, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Ozark Co. Clear Springs Cem
18. (a) Signature of funeral director Hal Thomburgh
(b) Address West Plains, Mo.
19. (a) (Date received local registrar) (b) C A Beach (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6 year 1940 hour 10 minute P. M.
21. I hereby certify that I attended the deceased from Jan 6, 1940 to Jan 6, 1940; that I last saw him alive on Jan 6, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Mitral Insufficiency	11-1939
Due to:	
Due to: N D N	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

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 C A Beach (M. D. or other) MD
Address Elsey Mo Date signed 2-6-40

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED
District Health Officer No. 6,
District File Number 2010-600
Date Filed FEB 20 1940

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Not embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.