

FILED MAR 8 - 1948

State File No. _____

Registration District No. 322

Primary Registration District No. 5446

Registrar's No. 8

1. PLACE OF DEATH:
(a) County Greene Missouri
(b) City or town Fair Grove R-2
(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)
In this community 4 yrs years, months or days)

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

3. (a) PRINT FULL NAME JOHN HENRY CALL
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 widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 21, 1858
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 23 year 1940 hour 5 minute 15 P. M.
21. I hereby certify that I attended the deceased from 2-23-1940 to 2-23-1940
that I last saw him alive on 2-23-1940 and that death occurred on the date and hour stated above.

8. AGE: Years 81 Months 7 Days 2 If less than one day _____ hr. _____ min.

Immediate cause of death Acute Nephritis Duration _____
Due to _____
Due to _____
Other conditions Senility
(Include pregnancy within 3 months of death)

MOTHER FATHER
12. Name John M Call
13. Birthplace W. Va.
14. Maiden name Elizabeth Chapman
15. Birthplace W. Va.
16. (a) Informant's own signature Maie Stewart
(b) Address Fair Grove R 2
17. (a) Burial (b) Date thereof 2-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Brick church
18. (a) Signature of funeral director Leann
(b) Address Springfield, Mo
19. (a) 2/26/40 (b) Alan Passes
(Date received local registrar) (Registrar's signature)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature W. J. Kelly (M. D. or other) _____
Address Springfield, Mo Date signed 2-26-40

WHILE FILLING IN 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 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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.

Signed W. Lloyd N. Fox

Licensed Embalmer No. 2910

P. O. Address 179 W. Walnut

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 66887

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 322

Primary Registration District No. 3446

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Franklin T.P.
(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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME John Henry Call

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 81 Months 7 Days 2 If less than one day _____ h. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 23
year 1970 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.
Immediate cause of death Acute Nephritis duration _____

Due to Arteriosclerosis and Senility
Due to _____

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

Major findings:
Of operations 120
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? _____

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

23. Signature W. Kelley (M. D. or other) _____
Address Springfield Date signed _____

SUPPLEMENTAL

