

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

145745

State File No. _____

Registration District No. 102

Primary Registration District No. 5227

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Rural West Peculiar Twp
(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) 2
(d) Length of stay: In hospital or institution 2
(Specify whether
In this community life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass
(c) City or town Rural (West Peculiar Twp)
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME James Hardin Calloway (LOD)

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 Clara Calloway 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased March, 14, 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 1 7 _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER { 12. Name Tom Calloway

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

14. Maiden name Kate Wells

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

16. (a) Informant Mrs. J. Hardin Calloway

(b) Address Peculiar, Mo.

17. (a) Burial (b) Date thereof April 23, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wills Cem., Peculiar

18. (a) Signature of funeral director E. K. George & Sons

(b) Address Belton, Mo.

19. (a) April 22, 1940 (b) Martin E. Robinson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21
year 1940 hour 7 minute 10 P.M.

21. I hereby certify that I attended the deceased from Nov 24, 1939 to April 21, 1940
that I last saw him alive on April 20, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Splenic Leukemia

Due to _____

Due to _____ 72

Other conditions (Include pregnancy within 3 months of death)

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? _____

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

23. Signature J. O. Scott (M. D. or other)

Address Harbisonville, Mo. Date signed 4/22

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 J. H. George

Licensed Embalmer No. 3675

P. O. Address Gambour, 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.