

FIVE JUN 10 1940

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

17853
Do not use this space.

1. PLACE OF DEATH *Buchanan* 85
 (a) County *Buchanan* Registration District No. *85*
 (b) Township *St Joseph, Mo.* Primary Registration District No. *1001* Registered No. *491*
 (c) City *St Joseph, Mo.* (d) Street No. *1722 S 9th* St.
 (e) Length of residence in city or town where death occurred yrs. *4* mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME *240* *JAMES McCall*
 (a) Residence, No. *1722 So. 9th* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *(None)*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan. 3 - 1867*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 3 28
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Retired Farmer*
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5th May 1, 1940*
 22. I HEREBY CERTIFY, That I attended deceased from *March 19, 1940* to *May 1, 1940*
 I last saw him alive on *April 30, 1940* Death is said to have occurred on the date stated above, at *7 A.* m.
 The principal cause of death and related causes of importance were as follows:
Carcinoma of stomach Date of onset *4/1*
 Other contributory causes of importance: *Secondary anemia* & *who*
 Name of operation *None* Date of *None*
 What test confirmed diagnosis? *Clinical* Was there an autopsy? *No*
 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) *Ed Grant M.D.* I, M. D.
 (Address) *St. Joseph, Mo.*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Edgerton, Mo.*
 FATHER
 13. NAME *Robert McCall*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Platte Co., Missouri*
 MOTHER
 15. MAIDEN NAME *Sarah West*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*
 17. INFORMANT (ADDRESS) *Mrs. Fattie Adams*
1722 S. 9th St. Joseph, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Union Hill Cem.* DATE *5/3 1940*
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Edgerton, Mo. Virian Ballins*
 20. FILED *May 1, 1940* *St. Joseph, Mo.* Local Registrar *85*

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS 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.

I X16805

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 *Vivian Rollins Nash*

Licensed Embalmer No. *3947*

P. O. Address *Edgerton, 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.