

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.

FILED SEP 5 1940
Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Law
(c) Name of hospital or institution: 906 E. 14th None 21
(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) 20 yrs
In this community Almeta V. Stewart Callis

3. (a) PRINT FULL NAME Almeta V. Stewart Callis
3. (b) If veteran, name war. No ✓
3. (c) Social Security No. No ✓

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Joseph Newton Callis
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased Aug 11 - 1896
(Month) (Day) (Year)

8. AGE: Years 44 Months NO Days 2 If less than one day ✓ hr. ✓ min.

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

10. Usual occupation Wife

11. Industry or business
12. Name Jack Dodson
13. Birthplace Law
(City, town, or county) (State or foreign country)
14. Maiden name Bertha Blair
15. Birthplace Kan
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joseph Newton Callis
(b) Address 906 East 14th St.

17. (a) Burial (b) Date thereof Aug 15 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director A. P. Doshler
(b) Address 1415 East 15

19. (a) Aug. 14, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 906 East 14-
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 13
year 1940 hour _____ minute 30 M.
21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death Asphyxia Duration _____

Avoidance of morphine
Morphine addiction
Other conditions (Include pregnancy within 3 months of death) 76B

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) Do not know
(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) (If physician or nurse)
23. Signature Victor H. [unclear] (M. D. or other) _____
Address K. C. Mo Date signed _____

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 *H. P. Doshier*

Licensed Embalmer No. *1166 Mo*

P. O. Address *1415 East 15*

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.