

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29938

State File No.

17-39
X21492

Registration District No. 18

Primary Registration District No. 6139

Registrar's No.

1. PLACE OF DEATH:

(a) County Texas
 (b) City or town (Rural) Morris 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)
 (d) Length of stay: In hospital or institution 2
 (Specify whether _____)
 In this community _____
 years, months or days

8. (a) PRINT FULL NAME Susan McCall 2110

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

6. (b) Name of husband or wife Frank McCall 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Jan 11 1879
 (Month) (Day) (Year)

8. AGE:			If less than one day hr. min.
Years	Months	Days	
<u>61</u>	<u>7</u>	<u>15</u>	

9. Birthplace Texas County, Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel Hartgrave 9

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

MOTHER FATHER { 14. Maiden name Mary Greenleaf 9

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

16. (a) Informant Frank McCall

(b) Address Calool, Missouri

17. (a) Burial (b) Date thereof Aug. 27, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Thoylod E. Head

(b) Address Calool, Missouri

19. (a) Aug 27 1940 (b) Paul B. McCall
 (Date of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26
 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased on
8/23/40 19____ to 8/23/40 19____
 that I last saw h. or alive on 8/23/40 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 1 wk

Due to arterio-sclerosis and Hypertension

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? _____

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

23. Signature Gaylord E. Head, M.D.
 Address Calool, Mo Date signed 8/24/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number 9401920

Date Filed _____

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.