

FILED APR 25 1942

Registration District No. 349

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
 (c) Name of hospital or institution 1627-12 Belview  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 75 years (Specify whether years, months or days)  
 In this community 75 years

3. (a) PRINT FULL NAME JOSEPH N. CALLIS

3. (b) If veteran, name was Spanish Am War 3. (c) Social Security No. 700

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife Almeta V. Callis 6. (c) Age of husband or wife if alive 11-1880  
 7. Birth date of deceased Jan 11-1880  
 (Month) (Day) (Year)

8. AGE: Years 62 Months 2 Days 28 If less than one day hr. min.

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

10. Usual occupation Laborer

MOTHER, FATHER

12. Name Chas Callis  
 13. Birthplace Ky  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Frank Francis Callis  
 15. Birthplace Ky  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Coroner's Office  
 (b) Address K.C. Mo.

17. (a) Burial (b) Date thereof 4-15-42  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Naperville, Kan

18. (a) Signature of funeral director Bugman Funeral Home  
 (b) Address Kan City, Mo.

19. (a) 4/14/42 (b) H. M. Grove  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
 (c) City or town Kansas City  
 (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.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 9 year 42  
 hour 6:15 minute P. M.

21. I hereby certify that deceased died on 4-9-42 at 6:15 P.  
 that I last saw him alive on 4-9-42 at 6:15 P.  
 and that he remained on the date and hour stated above.

Immediate cause of death Acute dilatation of the stomach  
 Duration

Due to

Other conditions (Include pregnancy within 3 months of death)

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)  
 (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

28. Signature H. M. Grove (M. D. or other)  
 Address K.C. Mo. Date signed

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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.....

*Harry E. Bugman*

Licensed Embalmer No. *2041*

P. O. Address. *Kc 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. .... Primary-Registration District No. .... Registrar's No. **1473**

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

1. PLACE OF DEATH:

(a) County .....  
(b) City or town .....  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**1627 Belleview**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution ..... (Specify whether  
In this community ..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME **Joseph N. Callis**

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

4. Sex **Male** 5. Color or race ..... 6. (a) Single, widowed, married, divorced .....  
6. (b) Name of husband or wife ..... 6. (c) Age of husband, or wife, if alive ..... years

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

8. AGE: Years Months Days If less than one day  
**62 yrs.** hr. 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) (Burial, cremation, or removal) ..... (b) Date thereof. (Month) (Day) (Year)  
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....  
(b) Address **6/10/42**

19. (a) **6/10/42** (Date received local registrar) **M. M. Brown** (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. **906 E. 14th Street** (If rural, give location)  
(e) If foreign born, how long in U. S. A.? ..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **9th**  
year **1942** 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 dilatation of stomach**

Due to .....  
Due to ..... **118.3**  
Other conditions **n m o**  
(Include pregnancy within 3 months of death)

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) .....  
(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 ..... (M. D. or other) .....  
Address ..... Date signed .....

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