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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. *21889*  
Registrar's No. *1889*

REG JUL 15 1942  
Registration District No. *5806*

Primary Registration District No. *436-1-5799*

*Cowan*

1. PLACE OF DEATH:  
(a) County *New Madrid*  
(b) City or town *Cowan*  
(c) Name of hospital or institution: *12 years*  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community *12 years*  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State *Missouri* (b) County *New Madrid*  
(c) City or town *Cowan*  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME *John Thomas Call*  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month *June*, day *15*  
year *1942* hour *2* minute *25* P.M.

4. Sex *Male* 5. Color or Race *W.*  
6. (b) Name of husband or wife *Fancy Bell Call*  
6. (a) Single, widowed, married, divorced, *Married*  
6. (c) Age of husband or wife if alive *57* years  
7. Birth date of deceased *2 1874*  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *April 1942* to *June 15 1942*  
that I last saw him alive on *June 10 1942*  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
*67 7 13* hr. min.

Immediate cause of death: *Myocardial infarction* Duration *6 days*

9. Birthplace *Flournoe* *1874*  
(City, town, or county) (State or foreign country)

Due to *Myocardial failure* *2 months*  
Due to *Rheumatic fever* *30 yrs?*  
*Recurrent attacks*

10. Usual occupation *Farmer*

Other conditions (Include pregnancy within 3 months of death) *none*

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name *Robert Call*  
13. Birthplace *1874*  
(City, town, or county) (State or foreign country)  
14. Maiden name *unknown*  
15. Birthplace *9*  
(City, town, or county) (State or foreign country)

Major findings: *none*  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant *Hella Call Farmer*  
(b) Address *Portageville Mo.*  
17. (a) \_\_\_\_\_ (b) Date thereof *June 16-42*  
(Burial, cremation, or removed) (Month) (Day) (Year)

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? \_\_\_\_\_

18. (a) Signature of funeral director *Dr. F. B. ...*  
(b) Address *Portageville Mo.*  
19. (a) *July 6 42* (b) *Edith Largent*  
Date received local registrar (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature *R. C. Cowan* (M. D. or other) *MD*  
Address *Portageville, Mo* Date signed *6-15-42*

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

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2

District File Number 742-857

Date Filed JUL 13 1942

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.....

*Noel C. Dean*  
.....  
Licensed Embalmer No. 3941

P. O. Address.....  
*Portaquillo*  
.....

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 21839

Registration District No. 274

Primary Registration District No. 5798

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Rural  
(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 \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John J. Call  
3. (b) If veteran \_\_\_\_\_ name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month January Day \_\_\_\_\_  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ live on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Sept. 2  
(Month) (Day) (Year)

Due to hypostatic pneumonia  
bronchial  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years 67 Months 7 Days \_\_\_\_\_  
(If less than one day \_\_\_\_\_ min.)  
9. Birthplace Ala.  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation \_\_\_\_\_  
11. Industry of business \_\_\_\_\_  
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)

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?  
\_\_\_\_\_ (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

107

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

