

No. 2  
-5-42  
5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31416**  
Registrar's No. **8**

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

Registration District No. **60**

Primary Registration District No. **5235**

1. PLACE OF DEATH:

(a) County Cedar

(b) City or town Rural-Benton Township  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: XXX /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XX  
(Specify whether)

In this community XXX  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cedar **20**

(c) City or town Rural-Benton Township  
(If outside city or town limits, write "RURAL")

(d) Street No. XXX (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country XXX **0**

3. (a) PRINT FULL NAME Emma Belle McCallister

3. (b) If veteran, name war XX

3. (c) Social Security No. XX

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 14  
year 1943 hour 2:15 minute P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h. alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

4. Sex Female / 5. Color or race white

6. (a) Single, widowed, married, divorced, widowed 2

6. (b) Name of husband or wife J. T. McCallister

6. (c) Age of husband or wife if alive XXX years

7. Birth date of deceased Sept. 11, 1873  
(Month) (Day) (Year)

Immediate cause of death angina pectoris

Due to \_\_\_\_\_

Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day

69 11 3 XXXXXXXXXX min.

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

Other conditions Hypertension  
(Include pregnancy within 3 months of death)

Chronic myocarditis

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

Of autopsy 93A

MOTHER FATHER

10. Usual occupation Housewife

11. Industry or business XXXXXX

12. Name S. Woods

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

14. Maiden name Maria Hillyer

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

16. (a) Informant Bertie Malloy

(b) Address Barsons, Kansas

17. (a) Burial (b) Date thereof 8-15-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hall Cemetery

18. (a) Signature of funeral director CHURCH AND NEALE

(b) Address STOCKTON, MISSOURI

19. (a) Sept 3, 1943 (b) J. P. Schorn  
(Date received local registrar) (Registrar's signature)

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 J. P. Schorn (M. D. or other) **8-15-43**

Address Genoa Springs Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7,

District File Number 9-43-877

Date Filed 10-5-43

---

---

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.

*not embalmed*

Signed E. H. Neal

Licensed Embalmer No. 3335

P. O. Address.....

**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, fact should be so stated above.**