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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 14 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16006
4713

Registration District No. 353

Primary Registration District No. 6202

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County. TEXAS
(b) City or town. RURAL CARROLL
(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. 1
In this community. 25 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State. MISSOURI (b) County. TEXAS 107
(c) City or town. RURAL
(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. HILBERT FINIS McCALLISTER

MEDICAL CERTIFICATION

3. (b) If veteran, name war
3. (c) Social Security No. 495-16-6517/1944

20. DATE OF DEATH: Month FEB. day 2
year 9 hour 10 minute AM.

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced. SINGLE

21. I hereby certify that I attended the deceased from 19 00 2-2
that I last saw him alive on 19 00 2-2
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased. AUG. 23 1918
(Month) (Day) (Year)

Immediate cause of death An over dose of sleeping tablets self administered.

8. AGE: Years 25 Months 5 Days 9
If less than one day hr. min.

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

9. Birthplace Texas Co. MO
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

MOTHER FATHER { 12. Name HERBERT McCALLISTER
13. Birthplace TEXAS CO. MO
(City, town, or county) (State or foreign country)
14. Maiden name. MERTLE KIRKMAN
15. Birthplace SUMMERSVILLE MO
(City, town, or county) (State or foreign country)

Major findings: Of operations
Of autopsy
PHYSICIAN Underline the cause to which death should be charged statistically.

16. (a) Informant HERBERT McCALLISTER
(b) Address SUMMERSVILLE MO

22. If death was due to external causes, fill in the following: V 107
(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?

17. (a) BURIAL (b) Date thereof 2/6/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BETHEL

18. (a) Signature of funeral director Hayland V. Elliott
(b) Address HOUSTON, MO

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

19. (a) (Date received local registrar) (b) (Registrar's signature)

23. Signature Dr. H. Reed (M. D. or other)
Address Summersville Date signed 2-5-44

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

1347

4159-71-564

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 Frank E. Wood

Licensed Embalmer No. 4026

P. O. Address Houston, 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, fact should be so stated above.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Levas
 (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)

3. (a) PRINT FULL NAME Albert F. McCallister

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

4. Sex m 5. Color or race w
 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 aug. 23
(Month) (Day) (Year)

8. AGE: Years 25 Months 5 Days _____
If less than one day _____ 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (c) 2/10/44 (b) Mrs Paul Rice
(Date received local registrar) (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. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day _____
 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 an overdose of sleeping tablets

Due to self administered

to signonant of the effect of these drugs,

a large amount of medicine

Other condition found on his person
(Include pregnancy within 3 months of death)

Major findings: renalata

Of operations phenobarbital, phenytoin

Of autopsy no other, probably accidental

Duration

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)
 Means of injury _____

23. Signature Dr. J.M. Peeds (M. D. or other) _____

Address Summersville, Mo. Date signed 2/17/44

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

SUPPLEMENTAL

4713

MAY 8 1944