7. S. No. 2
0M—5-42
ev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 9 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

24668

State File No. .....

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 619

1. PLACE OF DEATH:
(a) County: GREENE
(b) City or town: SPRINGFIELD
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1850 N. LYON AVE.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO. (b) County: GREENE 39
(c) City or town: SPRINGFIELD 26
(If outside city or town limits, write "RURAL")
(d) Street No.: 1850 N. LYON AVE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country: ✓

3. (a) PRINT FULL NAME: DOCTOR FRANKLIN CALLAHAN
3. (b) If veteran, name war: NONE
3. (c) Social Security No.: NONE
4. Sex: MALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: DIVORCED
6. (b) Name of husband or wife: UNK.
6. (c) Age of husband or wife if alive: UNK years
7. Birth date of deceased: JUNE (Month) 7 (Day) 1855 (Year)
8. AGE: Years 89 Months 1 Days 19 If less than one day ..... hr. ..... min.
9. Birthplace: SALEM (City, town, or county) MO. (State or foreign country)
10. Usual occupation: RETIRED R.R. EMPLOYEE
11. Industry or business: CAR CARPENTER.
FATHER
12. Name: WM CALLAHAN
13. Birthplace: UNKNOWN (City, town, or county) UNKNOWN (State or foreign country)
MOTHER
14. Maiden name: MARY BELL
15. Birthplace: DENT CO (City, town, or county) MO. (State or foreign country)
16. (a) Informant: Wm L. Callahan
(b) Address: 2130 N. Douglas, Springfield, MO.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 2 1944 (Month) (Day) (Year)
(c) Place: burial or cremation: Green Lawn Cem.
18. (a) Signature of funeral director: J. W. Klingner & Co.
(b) Address: Springfield MO
19. (a) 7-29-44 (Date received local registrar) (b) D. W. Hardley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 26 year 1944 hour 5 minute 40 A.M.
21. I hereby certify that I attended the deceased from January 1944, to July 26 1944, that I last saw h. alive on June 14 1944, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerosis and Chronic Myocarditis	
Due to	
Other conditions (Include pregnancy within 3 months of death) 938	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: D. F. Youell (M. D. or other) D.O.
Address: 234½ E. Commercial Date signed: 7/26/44
Springfield, Mo.

984 (Licensed Embalmer's Statement on Reverse Side)

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 Ogle Stone Jr.

Licensed Embalmer No. 4976

P. O. Address Springfield

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.