

3. No. 2
M-8-43
v. 5-17-39
I X37823

14786

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 27 1945

Registration District No. _____

Primary Registration District No. 6196

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Rural - Sherrill Tex
(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 Mo (b) County Howell

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

(d) Street No. 4 West of Cottersville Mo
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sarah Ronda Callahan

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15
year 1945 hour 4 minute 30 P M.

21. I hereby certify that I attended the deceased from 3-10-45 1945 to 3-15-45 1945
that I last saw h. a alive on Mar - 10 1945
and that death occurred on the date and hour stated above.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Lewis Callahan

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

7. Birth date of deceased July P 1865
(Month) (Day) (Year)

Immediate cause of death Pneumonia

Duration _____

8. AGE: Years 79 Months 8 Days 7
If less than one day _____ hr. _____ min.

Due to _____

Due to _____

9. Birthplace Not know Ill
(City, town or county) (State or foreign country)

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

Major findings: Of operations _____

Of autopsy _____

10. Usual occupation House work

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Not know

13. Birthplace Not know

14. Maiden name Not know

15. Birthplace Not know

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? _____

16. (a) Informant girl Fox

(b) Address Licking Mo

17. (a) Burial (b) Day thereof 3-14-45
(Burial, cremation, or reposal) (Month) (Day) (Year)

(c) Place: burial or cremation Callahan's Cem Howell Mo

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Lester Handell (M. D. or other)
Address Licking Date signed 3-15-45

18. (a) Signature of funeral director Smith & Ferguson

(b) Address Licking Mo

19. (a) 1945 (b) Maggie Callahan
(Served local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

0007

RECEIVED

District Health Officer No. 5,

District File Number

445-213

Date Filed

4-24-45

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.....

Not Embalmed

....., Registered Apprentice No.

working under my personal supervision.

Signed

Cubert E. Ferguson

Licensed Embalmer No.

3945

P. O. Address

Licking 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.