

DEPARTMENT OF HEALTH OF MISSOURI  
 BUREAU OF THE CENSUS  
 AUG 22 1945 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3343

1. PLACE OF DEATH:  
 (a) County JACKSON  
 (b) City or town KANSAS CITY  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
3518 TROOST AVENUE /  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community LIFE TIME  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County JACKSON  
 (c) City or town KANSAS CITY  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3518 TROOST AVENUE  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MISS CATHERINE M. CALLAHAN  
 (b) If veteran, name war NO  
 (c) Social Security No. 486-09-8580

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month AUG, day 9  
 year 1945 hour 6 minute 55A M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_,  
 and that death occurred on the date and hour stated above.

4. Sex FEM. 5. Color or race WH.  
 6. (a) Single, widowed, married, divorced SINGLE  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased OCTOBER 4 1902  
 (Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
 Due to coronary sclerosis  
 \_\_\_\_\_  
 Due to plum sclerosis  
 \_\_\_\_\_

8. AGE: Years 42 Months 10 Days 5  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Duration \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death) 940

9. Birthplace KANSAS CITY MISSOURI  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation SECRETARY WORK

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy no  
Autopsy & report

11. Industry or business ADDRESSOGRAPH SALES  
 12. Name JOSEPH A. CALLAHAN  
 13. Birthplace ST. LOUIS MISSOURI  
 (City, town, or county) (State or foreign country)  
 14. Maiden name LVA UNDERWOOD  
 15. Birthplace ST. LOUIS MISSOURI  
 (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? \_\_\_\_\_

16. (a) Informant Mrs. Lva Underwood  
 (b) Address St. Louis Missouri  
 17. (a) CREMATION (b) Date thereof AUG 11 1945  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation QUIN NEWCOMERS SONS  
 18. (a) Signature of funeral director D. J. Newcomer Sons  
 (b) Address 1401 Brush Creek Blvd  
 19. (a) 8-9-45 (b) Deraldine Holm  
 (Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
 (c) Means of injury 3 Car  
 23. Signature J. J. Walker (M. D. or other) \_\_\_\_\_  
 Address 1424 1/2 W. 14th Date signed 8-9-45

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

**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 Emile M. Colburn

Licensed Embalmer No. 3506

P. O. Address KC 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.**