DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

34775

State File No.

FILED NOV 27 1945

Registration District No. 327 Primary Registration District No. 3072 Registrar's No. 150

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

**1. PLACE OF DEATH:**

(a) County Saline

(b) City or town Marshall, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Fitzgibbon's Hospital 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days (Specify whether

In this community 2 Days years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Cleveland (b) County 999

(c) City or town Ohio 33 (If outside city or town limits, write "RURAL")

(d) Street No. 3127 West 115 0 (If rural, give location)

(e) Citizen of foreign country? Yes 2 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Harriet Marie McCaleb

3. (b) If veteran, name war #

3. (c) Social Security No. #

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Wilton John McCaleb

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased May (Month) 12 (Day) 1897 (Year)

8. AGE: Years 48 Months 5 Days 0 If less than one day hr. min.

9. Birthplace Cleveland (City, town, or county) Ohio (State or foreign country)

10. Usual occupation Housewife

11. Industry or business " "

FATHER
12. Name Charles Wohlotz
13. Birthplace Unknown (City, town, or county) Germany 4 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant Wilton John McCaleb

(b) Address Cleveland, Ohio

17. (a) ~~Burial~~ Removal (Burial, cremation, or removal) (b) Date thereof 10/18/45 (Month) (Day) (Year)

(c) Place: burial or cremation Cleveland, Ohio Cemetery

18. (a) Signature of funeral director A. Leslie Sussman

(b) Address Marshall, Mo.

19. (a) 10-12-45 (Date received local registrar) (b) Mrs T. O. Westbrook (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 12 year 1945 hour 7:30 minute A M.

21. I hereby certify that I attended the deceased from Oct 10, 1945, to Oct 12, 1945; that I last saw her alive on Oct 12, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Acute Uremia — Duration 12 hrs

Due to Shock sustained in bus accident

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) accident

(b) Date of occurrence 97

(c) Where did injury occur? #40 Hwy (City or town) Saline, Co (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway #40 U.S. (Specify type of place)

While at work? (e) Means of injury Bus

23. Signature W. T. Mix M.D. (M. D. ~~or other~~)

Address Marshall, Mo Date signed 10/12/45

1215

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
11-6-45

JAN 10 1950

JAN 23 1946

NOV 8 1945

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**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 J. Leslie Sursney

Licensed Embalmer No. 32351

P. O. Address Marshall, 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.**

S. No. 2B
0M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 150

SUPPLEMENTARY

**1. PLACE OF DEATH:**

(a) County Saline

(b) City or town Marshall
(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 (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

3. (a) PRINT FULL NAME Harriet M. McCaleb

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 12 (Day) 1889 (Year)

8. AGE: Years 48 Months 5 Days 0 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 12 year 1945 hour minute 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.

Immediate cause of death

Due to

Due to Shock from bus accident.

Other conditions
(Include pregnancy within 3 months of death)

Bus was crowded off

Major findings:
Of operation Highway by auto & bus ran into
Of autopsy concrete Colvert

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 Oct 10, 1945

(c) Where did injury occur? Highway 40 (City or town) Saline (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway 40 (Specify type of place)

While at work? Traveling (e) Means of injury Bus

23. Signature W. K. M. H., M. D. (M. D. or other)

Address Date signed

JAN 23 1945

34775