

S. No. 2
M-5-43
v. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7303**
Registrar's No. **1887**

FILED MAR 7 1946
318

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Lutheran Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 yrs
(Specify whether
In this community 25 yrs
years, months or days)

3. (a) PRINT FULL NAME Delia Callaway
3. (b) If veteran, name war no 3. (c) Social Security No. none
4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Richard 6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 18, 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 8 6 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Shannon
13. Birthplace Fredericktown, Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Samuel Callaway son 1

(b) Address 3543 Crittenden Street

17. (a) Burial (b) Date thereof 2-27-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fredericktown, Missouri

18. (a) Signature of funeral director [Signature]

(b) Address 2301 Lafayette Av. St. Louis, Mo.

19. (a) FEB 25 1946 (b) J. J. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Carroll
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 167
(d) Street No. 3543 Crittenden Street
(If rural, give location) 9
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February 24
year 1946 hour _____ minute _____ P.M.

21. I hereby certify that I attended the deceased from Nov., 1943, to Feb. 24, 1946;
that I last saw her alive on Feb. 24, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerosis
Due to Chronic arteriosclerosis
Duration 8 yrs

Due to 93
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: none
Of operations _____
Of autopsy none

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) (e) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address 3415 S. Grand Date signed 2/25/46

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.....

L R Cooper

Licensed Embalmer No. *3633*

P. O. Address *2301 Lafayette Ave*

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.