S. No. 2
M—5-43
. 5-17-39
I X36671

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. 14085

FILED MAY 13 1946

Registration District No. 2 Primary Registration District No. 5947 Registrar's No. 13

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town St. James Twp. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Soldiers Home Hospital 5 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 mints (Specify whether

In this community 2 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps 81

(c) City or town Rural 0 (If outside city or town limits, write "RURAL")

(d) Street No. — 0 (If rural, give location) 0

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

If yes, name country —

3. (a) PRINT FULL NAME Grace M Callicott

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex F 1

5. Color or race W

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

6. (b) Name of husband or wife Mash A Callicott

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

7. Birth date of deceased Aug (Month) 19 (Day) 1872 (Year)

8. AGE: Years 73 Months 8 Days 3 If less than one day hr. min.

9. Birthplace (City, town, or county) Cell 1 (State or foreign country)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Dont Know
13. Birthplace (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) 9 (State or foreign country)

16. (a) Informant Soldiers Home Office

(b) Address St James Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23 46 (Month) (Day) (Year)

(c) Place: burial or cremation Soldiers Home

18. (a) Signature of funeral director O E Lickliter

(b) Address St James Mo

19. (a) May 2, 1946 (Date received local registrar) (b) Cara E Birmingham (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 4 day 21 year 1946 hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from 2-1945, 19 to April 21, 1946 that I last saw her alive on April 21, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary occlusion	2 days
Due to Arterio Sclerosis	3 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 9 4a

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 William H Brewer (M. D. or other) 0

Address St James Mo Date signed 4/22/46

(Licensed Embalmer's Statement on Reverse Side)

253

MAY 16 1945

MAY 27 1945

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 Me, Registered Apprentice No. ....., working under my personal supervision.

Signed Orce E Licklider

Licensed Embalmer No. 3546

P. O. Address Ft James 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.