

No. 2  
8-43  
5-17-39  
57825

State File No. ....

Registrar's No. 7

**FILED** SEP 14 1946

Registration District No. 7

Primary Registration District No. 5930

1. PLACE OF DEATH:

(a) County Crawford  
(b) City or town Rural Osage  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community all her life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? American (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Stella Meldora Callahan

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 W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased July 31 - 1933  
(Month) (Day) (Year)

8. AGE: Years 12 Months 10 Days 18 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Crawford Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Arthur J. Callahan

13. Birthplace Crawford Mo (City, town, or county) (State or foreign country)

14. Maiden name Sara Harris

15. Birthplace Crawford Mo (City, town, or county) (State or foreign country)

16. (a) Informant Louise Callahan

(b) Address Cherryville Mo

17. (a) \_\_\_\_\_ (b) Date thereof 6-13-1946 (Month) (Day) (Year)

(c) Place: burial or cremation Martin Cemetery

18. (a) Signature of funeral director James E. Logan

(b) Address Sheelville Mo

19. (a) Aug. 1946 (Date received local registrar) (b) Elsie Hanson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 12<sup>th</sup> year 1946 hour 3 minutes 30 P. M.

21. I hereby certify that I attended the deceased from 11 March 1946 to 25 May 46 that I last saw her alive on 25 May 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Acute nephritis Duration 3 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_

Of autopsy 30

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) (c) Means of injury L

23. Signature William H. Robey M.D. or other \_\_\_\_\_

Address Sheelville Mo Date signed Aug 1946

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

233

RECEIVED

District Health Officer No 5,

District File Number 946509

Date Filed 9-2-46

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 Ray Jones

was not embalmed....., Registered Apprentice No.....

working under my personal supervision.

Signed Ray Jones.....

Licensed Embalmer No. 2428

P. O. Address Steubenville MD

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 26686Registration District No. 91Primary Registration District No. 5320Registrar's No. 7

## 1. PLACE OF DEATH:

(a) County Crawford  
(b) City or town Rural  
(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 days3. (a) PRINT  
FULL NAME Stella M. Callahan3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex F 5. Color or race W  
6. (a) Single, widowed, married,  
divorced S6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased July 31  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
12 10 10 10 min.9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

## 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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_, 19 \_\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

\_\_\_\_\_

Due to Acute nephritisDue to not known.

\_\_\_\_\_

Due to \_\_\_\_\_

\_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

Duration  
3 months

130

PHYSICIAN \_\_\_\_\_

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

