

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8836

BIRTH NO. _____ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 2001 Registrar's No. 136

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>Cherokee</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Joplin</u> (1)	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Galena</u>	9-11
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Johns</u>		d. STREET ADDRESS (If rural, give location) <u>905 Elm</u> <u>2</u>	

3. NAME OF DECEASED (Type or Print) <u>CALLIE</u>	a. (First)	b. (Middle)	c. (Last) <u>LAWING</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>3</u> <u>19</u> <u>49</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Sept 20 1859</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Estel Co, Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>James Estes</u>	13b. MOTHER'S MAIDEN NAME <u>No Record</u>	13c. NAME OF HUSBAND OR WIFE <u>John W Lawing</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Ed Tollman</u>	ADDRESS <u></u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hip fracture, left</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility, Malnutrition</u> DUE TO (c) <u></u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>G 910 3</u>	

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u></u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Galena, Cherokee, Kans.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Mar. 18, '49 10a</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fall -</u> <u>136</u>
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22. I hereby certify that I attended the deceased from 18 Mar, 1949, to 19 Mar, 1949, that I last saw the deceased alive on 19 Mar, 1949, and that death occurred at 2:55 pm., from the causes and on the date stated above.

23a. SIGNATURE <u>Robert G. Powell M.D.</u> (Degree or title)	23b. ADDRESS <u>Galena, Kansas</u>	23c. DATE SIGNED <u>19 Mar 49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>3-21-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Clark Hill</u>	24d. LOCATION (City, town, or county) (State) <u>Galena Kans</u>
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DATE REC'D BY LOCAL REG. <u>3-21-49</u>	REGISTRAR'S SIGNATURE <u>Ed James</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ed James</u> ADDRESS <u>Potter Funeral Home Galena</u>
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49-3-253

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

Clara Thornhill

Signed.....

Student Embalmer

Licensed Embalmer No. *3590*

P. O. Address *Joplin, 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.