

FILED MAR 30 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 9645

BIRTH NO. _____		REG. DIST. NO. 310		PRIMARY REG. DIST. NO. 3058		Registrar's No. 59		
1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. LENGTH OF STAY (in this place) <u>few hours</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Elsberry</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>South Second St.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>PAMELA</u>			b. (Middle) <u>LEE</u>		c. (Last) <u>CALNAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3-16-49</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>		8. DATE OF BIRTH <u>June 14, 1949</u>	9. AGE (In years last birthday) <u>1</u>	# UNDER 1 YEAR <u>9</u> Months	# UNDER 24 HRS. <u>2</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Kansas City Gen'l Hosp.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Thos. Lee Calnan</u>			13b. MOTHER'S MAIDEN NAME <u>Ellen Hoxsey</u>		14. NAME OF HUSBAND OR WIFE -----			
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>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Thos. Lee Calnan</u>		ADDRESS <u>Elsberry</u>		
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Meningococci or Pneumococci</u>				ANCECEDENT CAUSES <u>Meningitis</u> DUE TO (b) <u>acute sinusitis? otitis media?</u>				
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>Possible Brain Abscess</u>								
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None + Blood cultures</u>								<u>3''</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. <u>no</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>3/15</u> , 19 <u>49</u> , to <u>3/16</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>3/16</u> , 19 <u>49</u> , and that death occurred at <u>11:45</u> m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>R. O. Hayden MD</u>				23b. ADDRESS <u>St. Charles, Mo.</u>		23c. DATE SIGNED <u>3/17/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-17-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Elsberry city cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Elsberry, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>3-25-49</u>		REGISTRAR'S SIGNATURE <u>Barrie Hamilton</u>		FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Elsberry, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 9,
District File Number 3-29-49
Date Filed

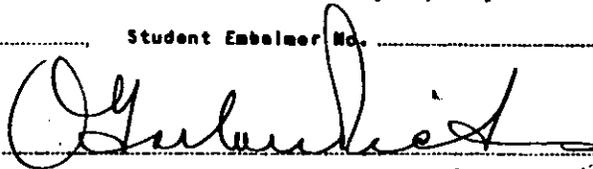
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____



Signed _____
Student Embalmer

Licensed Embalmer No. 4012

P. O. Address Edsberg, 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.