

FILED OCT 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29145

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>292</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution/residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Kirksville</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>Milan</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Grim-Smith Memorial Hospital</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>Andrew</u>		b. (Middle) <u>Jackson</u>		c. (Last) <u>Callihan</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>September 7 1949</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>January 28 1868</u>	
9. AGE (In years last birthday) <u>81</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		13a. FATHER'S NAME <u>William Callihan</u>		13b. MOTHER'S MAIDEN NAME <u>Rachel Jacobs</u>		14. NAME OF HUSBAND OR WIFE <u>Alice Jane Callihan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Hospital records</u> ADDRESS _____			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary sclerosis &amp; occlusion</u> DUE TO (c) <u>Coronary heart disease</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostatic obstruction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>10 days</u> <u>sev yrs</u> <u>1 yr</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>None</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) <u>4211</u>		(STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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>Aug 19, 1949</u> , to <u>Sept 7, 1949</u> , that I last saw the deceased alive on <u>Sept 7, 1949</u> , and that death occurred at <u>9:55 A. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>George E. Ginn, M.D.</u>				23b. ADDRESS <u>Kirksville, Missouri</u>		23c. DATE SIGNED <u>9-10-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 9-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Lawrence Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Milan (Rural) Mo</u>	
DATE REC'D BY LOCAL REG. <u>9-29-49</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hessman &amp; Son</u> ADDRESS <u>Milan Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED OCT 3 1949  
District Health Officer No. 10  
District File Number 10-49-168  
Date Filed OCT 3 1949

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.

Student .....  
Student Embalmer

Signed Samuel C. Diggins

Licensed Embalmer No. 3792

P. O. Address Melan. 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.