

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

29300

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1007

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>DeKalb</u>	
c. LENGTH OF STAY (in this place) <u>3 days</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Methodist Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Nola</u> b. (Middle) <u>S.</u> c. (Last) <u>Call</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 11, 1949</u>
5. SEX <u>male (r)</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>4/24/1881</u>
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u>	IF UNDER 2 HRS. Hours <u>17</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>agriculture</u>	11. BIRTHPLACE (State or foreign country) <u>Buchanan Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13a. FATHER'S NAME <u>S. D. Call</u>		13b. MOTHER'S MAIDEN NAME <u>Cuma Coats</u>	14. NAME OF HUSBAND OR WIFE <u>Iva/Call</u>
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 ADDRESS <u>Mrs. Iva Call DeKalb, Mo.</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> DUE TO (b) <u>chronic hypertension</u> <u>1 yr.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>331X</u> Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (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>2-17-46</u> , 19____, to <u>9-11-49</u> , 19____, that I last saw the deceased alive on <u>9/11/49</u> , 19____, and that death occurred at <u>2:20A.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>W. J. Jacobs</u>		23b. ADDRESS <u>411 Turkey Creek Bldg</u>	
23c. DATE SIGNED <u>9/12/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>9/12/1949</u>	
24c. NAME OF CEMETERY OR CREMATOR <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Sept. 19, 1949</u>		REGISTRAR'S SIGNATURE <u>E. K. Jenkins</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Hester Bowman Funeral</u>		ADDRESS <u>St. Joseph, Mo.</u>	

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

Dr. Maurice M. Janz
of W.H.R. Bldg.

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 *James R. Hawkins* _____

Licensed Embalmer No. *4535* _____

P. O. Address *319 S. 10th St. J. R. M.* _____

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.