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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 3 1949

State File No. 29882

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 855

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield
c. LENGTH OF STAY (in this place): 98 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St John's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE: Missouri
b. COUNTY: Dade
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural S.E. Everton
d. STREET ADDRESS (If rural, give location): Everton

3. NAME OF DECEASED (Type or Print)
a. (First): ELLA
b. (Middle):
c. (Last): CALLISON

4. DATE OF DEATH (Month) (Day) (Year): 9 23 49

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 18[illegible]2 7 1
9. AGE (In years last birthday): 78 — If under 1 year: Months 2, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: US
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Jim Callison
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Florence Jones

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cutaneous Sarcoma with metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Dermatitis Herpetiformis — 2 mos

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 19 48, *to* Sept 23, 19 49 *that I last saw the deceased alive on* Sept 23, 19 49, *and that death occurred at* 11:28 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. D. Duncan (Degree or title): MD
23b. ADDRESS: Med Arts Springfield Mo
23c. DATE SIGNED: 9-23-49.

24a. BURIAL, CREMATION, REMOVAL (Specify): Buried
24b. DATE: 9-25-49
24c. NAME OF CEMETERY OR CREMATORY: Sinking Creek
24d. LOCATION (City, town, or county) (State): Dade County Mo

DATE REC'D BY LOCAL REG.: 10-1-49
REGISTRAR'S SIGNATURE: W. C. Hundley by Wilbur Dodd
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Morris-Seman Ash Grove Mo

(Attached Embalmer's Statement on Reverse Side)

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 Paul V. Gordy

Licensed Embalmer No. 479

P. O. Address Ash Grove, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.