

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **7624**

FILED APR 12 1954

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 4003 Registrar's No. 80

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY <u>Adair</u>		a. STATE <u>MISSOURI</u> b. COUNTY <u>ADAIR</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Gibbs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KIRKSVILLE</u> <u>0013</u>	
c. LENGTH OF STAY (in this place) <u>1 yr</u>		d. STREET ADDRESS (If rural, give location) <u>901 S. FLORENCE</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address of location) <u>McClanahan Nursing Home</u>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>ALMA</u>	b. (Middle) <u>CALLISON</u>	c. (Last) <u>FORD</u>	<u>APRIL 6 1954</u>		

5. SEX <u>M/F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>6-11-1880</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>WILLIAM CALLISON</u>	13b. MOTHER'S MAIDEN NAME <u>LILLIE HOLD</u>	14. NAME OF HUSBAND OR WIFE <u>D. E. FORD</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>N.O.</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>MRS. HADLEY HINKLE</u>	ADDRESS <u>KIRKSVILLE Mo</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>22 hrs</u>
	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>Apoplexy (Cerebral Thrombosis)</u> DUE TO (c) <u>Hypertension</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>no operation</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22: I hereby certify that I attended the deceased from Jan 8, 1952, to APRIL 6, 1954, that I last saw the deceased alive on APRIL 6, 1954, and that death occurred at 2:05 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>William C. Kelly, M.D.</u>	23b. ADDRESS <u>KIRKSVILLE, MO.</u>	23c. DATE SIGNED <u>APR 8, 54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>4-8-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>BULLION CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>ADAIR CO., MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>4-8-54</u>	REGISTRAR'S SIGNATURE <u>Kate Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>David Kugel</u>	ADDRESS <u>Kirkville, Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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MAY 13 1955

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

Donald W. Hegdal

Signed.....

Student Embalmer

Licensed Embalmer No. *4596*

P. O. Address *Kirksville, N.Y.*

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.