

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1816

FILED FEB 7 - 1955

BIRTH NO. _____ REG. DIST. NO. 227 PRIMARY REG. DIST. NO. 4339 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY MONROE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY MONROE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN PARIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN PARIS 0690	
c. LENGTH OF STAY (in this place) 19 YRS		d. STREET ADDRESS (If rural, give location) 430 COOPER AVE	
d. FULL NAME OF HOSPITAL OR INSTITUTION 430 COOPER AVE		d. STREET ADDRESS (If rural, give location) 430 COOPER AVE	

3. NAME OF DECEASED (Type or Print) a. (First) RUTH	b. (Middle)	c. (Last) CALLES	4. DATE OF DEATH (Month) (Day) (Year) FEB. 3, 1955
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH OCT. 22, 1905	9. AGE (In years last birthday) 49	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours	# UNDER 1 YEAR Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER OF CAFE	10b. KIND OF BUSINESS OR INDUSTRY CAFE	11. BIRTHPLACE (City and State or Foreign Country) QUINCY, ILL.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME (First Name Nk.) ACKERMAN	13b. MOTHER'S MAIDEN NAME (First Name Nk.) GRIMMER	14. NAME OF HUSBAND OR WIFE MIL0 CALLES
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 486-38-7270	17. INFORMANT'S SIGNATURE OR NAME ROBT. CALLES, ST. LOUIS, MO.	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 27 hrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c)		
II. 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	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)	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 **3-9-1948 to 2-3-1955**, that I last saw the deceased alive on **2-3-1955**, and that death occurred at **10:57 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. A. Barnett M.D.	23b. ADDRESS PARIS, MO.	23c. DATE SIGNED 2-4-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE FEB. 6, 1955	24c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT	24d. LOCATION (City, town, or county) (State) QUINCY, ILL.
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DATE REC'D BY LOCAL REG. 2-4-55	REGISTRAR'S SIGNATURE J. A. Barnett, M.D.	435-0	25. FUNERAL DIRECTOR'S SIGNATURE Speed Blakey	ADDRESS PARIS, MISSOURI
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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 E. Magnaw

Licensed Embalmer No. 4000

P. O. Address PARIS, MISSOURI

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.