

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10738

State File No. ....

FILED MAR 29 1955

|  |  |  |  |   |   |   |   |  |
|--|--|--|--|---|---|---|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>341</u>  |  | PRIMARY REG. DIST. NO. <u>4509</u>  |   | Registrar's No. <u>21</u>   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Sullivan</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u> |   |   |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Humphreys</u>  |  | c. LENGTH OF STAY (in this place) <u>Life</u>  |  | c. CITY OR TOWN <u>Humphreys</u>  |   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION _____  |  |  |  | e. STREET ADDRESS (If rural, give location) <u>1050</u>   |   |   |   |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>IRVING</u> b. (Middle) _____ c. (Last) <u>MCCALLEY</u>  |  |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>3-18-1955</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>5-13-1888</u>   |   |  |
| 9. AGE (In years last birthday) <u>66</u>  |  | IF UNDER 1 YEAR Months _____ Days _____  |  | IF UNDER 1 HR. Hours _____ 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 _____                |   | 11. BIRTHPLACE (City and State or Foreign Country) <u>Linn Co. Ia.</u>              |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |  |
| 13a. FATHER'S NAME <u>Alden C. McCally</u>   |  |  | 13b. MOTHER'S MAIDEN NAME <u>Aldiebelle Canady</u>     |   | 14. NAME OF HUSBAND OR WIFE <u>Lola McCally</u>                                     |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>✓</u>  |  | 16. SOCIAL SECURITY NO. <u>✓</u>   |  | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Lola Cook McCally</u> ADDRESS <u>Humphreys, Mo</u>  |   |   |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Organic Heart Disease (mitral regurgitation)</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>?</u><br>ANTECEDENT CAUSES<br>DUE TO (b) _____<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death <u>Chronic Bright's Disease</u> <u>?</u> |  |   |   |   |   |  |
| 19a. DATE OF OPERATION _____   |  | 19b. MAJOR FINDINGS OF OPERATION _____   |  |   | 20. AUTOPSY?<br>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) <u>410 X</u>  |   |   |   |  |
| 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>1-1-1954</u> , to <u>2-18-1954</u> , that I last saw the deceased alive on <u>2-17-1955</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above. |  |  |  |   |   |   |   |  |
| 23a. SIGNATURE (Degree or title) <u>W.C. Weston M.D.</u>   |  |  |  | 23b. ADDRESS <u>Salt, Mo</u>  |   | 23c. DATE SIGNED <u>3-21-55</u>   |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 24b. DATE <u>3-22-55</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Humphreys Cem.</u>  |   | 24d. LOCATION (City, town, or county) (State) <u>Humphreys Mo</u>   |   |  |
| DATE REC'D BY LOCAL REG. <u>3-22-1955</u>  |  | REGISTRAR'S SIGNATURE <u>Mrs. H.B. Harris</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>DR Payne</u>  |   | ADDRESS <u>Linn Salt</u>  |   |  |

(Licensed Embalmer's Statement on Reverse Side)

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

1050

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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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 340

P. O. Address Galt

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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