

FILED MAY 17 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17455

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 340 PRIMARY REG. DIST. NO. 6151 Registrar's No. 44

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> <u>Stoddard</u>	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>rural</u>	c. LENGTH OF STAY (in this place) <u>4 yrs</u>	c. CITY OR TOWN <u>Parma</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) <u>3 1/2 miles N. of Parma</u> <u>1030</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Arville</u> b. (Middle) <u>Willie</u> c. (Last) <u>Callison</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April</u> <u>10</u> <u>1955</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 23 1900</u>	9. AGE (In years last birthday) <u>54</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>trucking and farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country)/ <u>Weekley County West. Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>J.D. Callison</u>		13b. MOTHER'S MAIDEN NAME <u>Sallie Gunn.</u>		14. NAME OF HUSBAND OR WIFE <u>Irene Callison</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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Irene Callison Parma 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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Insufficiency</u>		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4222</u>	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 1-19, 1955, to 4-10, 1955 that I last saw the deceased alive on 4/10, 1955, and that death occurred at 11:40P m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. Robert H. ...</u>	(Degree or title)	23b. ADDRESS <u>Parma, Mo.</u>	23c. DATE SIGNED <u>4/15/55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>April 13, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>Malden Missouri</u>

DATE REC'D BY LOCAL REG. <u>5/14/55</u>	REGISTRAR'S SIGNATURE <u>Delma H. Jenkins</u>	459-	25. FUNERAL DIRECTOR'S SIGNATURE <u>Walker Funeral Service</u>	ADDRESS <u>Parma, Mo;</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Marsh W Atkins*.....

Licensed Embalmer No. *471*.....

P. O. Address *Delaware*.....

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.