

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24059

FILED AUG 2 - 1955

State File No.
REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5869

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) BY3M29D		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Chronic Hospital		e. STREET ADDRESS (If rural, give location) 4933 Marfitt Place 2069	
3. NAME OF DECEASED (Type or Print) a. (First) Carlton		b. (Middle) Mc Call	
c. (Last) Mc Call		4. DATE OF DEATH (Month) (Day) (Year) July 6 1955	
5. SEX Male	6. COLOR (OR RACE) Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 1/13/1892
9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (City and State or Foreign Country) S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Mc Call	
13b. MOTHER'S MAIDEN NAME Salina Steele		14. NAME OF HUSBAND OR WIFE	
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.	
17. INFORMANT'S SIGNATURE OR NAME Chronic Hospital		ADDRESS 5600 Arsenal	
18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Septicemia - organism unknown		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		1 year	
II. OTHER SIGNIFICANT CONDITIONS		years	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. HOW DID INJURY OCCUR? 715X	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. DATE OF OPERATION	
21g. MAJOR FINDINGS OF OPERATION		21h. DATE	
21i. NAME OF CEMETERY OR CREMATORY Washington Park		21j. LOCATION (City, town, or county) (State) St Louis, MO	
21k. DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUL 7 1955 J. Carl Smith M.D.		21l. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. L. Beal Und. Co. 4303 Delmar	

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 *John K. Cunningham*.....

Licensed Embalmer No. *44*
P. O. Address *2405*.....

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.