Health, & Welfare
Public
Service

S. 300
v. 1-56

FILED APR 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9255
STATE FILE NUMBER

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 37

1. PLACE OF DEATH
a. COUNTY Lawrence
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Aurora — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Aurora Hospital — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Lawrence
c. CITY OR TOWN Aurora 0551 0 — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 303 W. Church (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Dorothy Middle: Eloise Last: McCall
4. DATE OF DEATH Month: March Day: 25 Year: 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Dec. 15-1908
9. AGE (In years last birthday) 48 — IF UNDER 1 YEAR: Months 3 Days 20 — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (City and state or country) Lawrence
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Clemmett Brown
14. MOTHER'S MAIDEN NAME Elizabeth May Baine
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO.
17. INFORMANT James C. McCall Address Aurora Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Intracranial Cerebro-vascular accident — 2 days
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 331X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Mar. 23/57 to Mar. 25/57 and last saw her/him alive Mar. 25/57
Death occurred at 12:42 p. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. McCallum (Degree or title) M.D.
22b. ADDRESS 215 W. Main Aurora
22c. DATE SIGNED Mar. 26/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 3/27/57
23c. NAME OF CEMETERY OR CREMATORY Maple Park
23d. LOCATION (City, town, or county) Aurora (State) Mo.

24. FUNERAL DIRECTOR Oscar L. Marsh ADDRESS Aurora Mo.
25. DATE RECD. BY LOCAL REG.
26. REGISTRAR'S SIGNATURE Ora McNatt

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

157-0

JUL 21 1964

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by .....Myself....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed...Oscar L. Ward...

Licensed Embalmer No. 38/2

P. O. Address Aurora...

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.