

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29294
STATE FILE NUMBER 8008

FILED SEP 4 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		STREET ADDRESS (If outside, give location) 5208 Gresham	
3. NAME OF DECEASED (Type or print) First John Middle M. Last Callahan		4. DATE OF DEATH Month August Day 25 Year 1957	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman, General Food Sales Co.		10b. KIND OF BUSINESS OR INDUSTRY Missouri	11. BIRTHPLACE (City and state or country) U.S.
13a. FATHER'S NAME Timothy Callahan		14. NAME OF HUSBAND OR WIFE Mrs. Emma Callahan	
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. 494-09-6576	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decomposition DUE TO (b) chronic myocardial disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 week 3-5 yrs.	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 422.2	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 Jan 56 to 25 Aug 57 and last saw him alive on 25 Aug 57 Death occurred at 10:20 am on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Rgt. Schumacher (Degree or title)		22b. ADDRESS 6817 Groves	
22c. DATE SIGNED 26 Aug 57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE August 28, 1957	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
24. FUNERAL DIRECTOR Walter J. Donnelly ADDRESS 3840 Lindell Blvd.		25. DATE RECD. BY LOCAL REG. AUG 27 57	
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part 1 must be causally related.

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 Francis Williams

Licensed Embalmer No. 3565
P. O. Address 3840 Lu

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.