

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33823

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8455**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis,		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hosp. -		Length of stay in 1b	STREET ADDRESS 5th STREET 6062a Cates Ave (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle R. Last MC CALLISTER			4. DATE OF DEATH Month Sept. Day 7, Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 17, 1885	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Merchant Retd.	11. BIRTHPLACE (City and state or country) Franklin City, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin McCallister			14. MOTHER'S MAIDEN NAME Martha Thurman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 189-16-6126	17. INFORMANT Address Anna D. McCallister-6062a Cates Ave		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertension DUE TO (c) Central Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) 331x					INTERVAL BETWEEN ONSET AND DEATH 24 h
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.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
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 12-15-57 to 9-6-57 and last saw ^{her} him alive on 9-6-57 Death occurred at 2:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) A. Hayden M.D.			22b. ADDRESS 730 Hodgson		22c. DATE SIGNED 9/7/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Sept. 10, 1957	23c. NAME OF CEMETERY OR CREMATORY Lake Charles		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR Kriegshausser-4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. SEP 9 57		26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

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 *Edwin J. McReynolds*

Licensed Embalmer No. *30*

P. O. Address

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