

pt. Health,
r., & Welfare
S. Public
alth Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38545
STATE FILE NUMBER
Registrar's No. 2393

FILED OCT 16 1957

Registration District No. 317 Primary Registration District No. 544

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Audrain	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		c. CITY OR TOWN Ladonia	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital		d. STREET ADDRESS (If outside, give location) Local	
Length of stay in lb 7 weeks		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Kemuel Last McCall			4. DATE OF DEATH Month Sept. Day 27 Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1876
9. AGE (In years birthday) 80	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Medicine	11. BIRTHPLACE (City and state or country) Calloway Co., Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME W.K. McCall		13b. MOTHER'S MAIDEN NAME Maggie Coates	
14. NAME OF HUSBAND OR WIFE Susanna			
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. Unknown	
17. INFORMANT Dr. E.L. McCall		Address 519 Wilcox - Kirkwood, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypernephroma			INTERVAL BETWEEN ONSET AND DEATH 2 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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.) 180X	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <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 Nov '55 to 9/27/1957 and last saw ^{her} _{him} alive on 9/27/57 Death occurred at 10:00 AM on 9/27/57 (on or after the date stated above; and to the best of my knowledge, from the causes stated.)			
22a. SIGNATURE Frank J. Paterson M.D.		22b. ADDRESS 333 S. Kirkwood Rd. Kirksville	
22c. DATE SIGNED 9/27/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-27-57	
23c. NAME OF CEMETERY OR CREMATORY Local Cemetery		23d. LOCATION (City, town, or county) Ladonia, Mo.	
24. FUNERAL DIRECTOR Albert H. Hoppe		ADDRESS 1700 Washington Blvd.	
25. DATE RECD. BY LOCAL REG. 9-28-57		26. REGISTRAR'S SIGNATURE Herbert B. Dumble MD	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

89

OCT 17 1957

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 Elton R. Rumbach

Licensed Embalmer No. 4293

P. O. Address St. Louis, Mo.

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.