

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41199

FILED NOV 18 1957

STATE FILE NUMBER

Registration District No. 230

Primary Registration District No. 4344

Registrar's No. 13

300
1-57

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

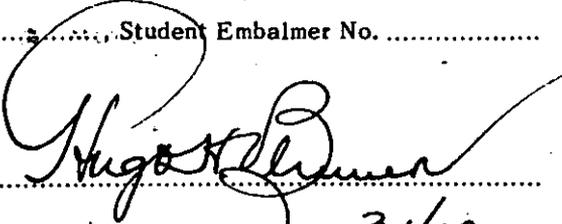
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>McKITTRICK</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>McKITTRICK</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u> </u>			Length of stay in lb <u>28 YRS</u>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GUSTAVE FRANK KALLMEYER</u>				4. DATE OF DEATH Month Day Year <u>Nov. 13-1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 3-1877</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRACK FOREMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RAILWAY</u>		11. BIRTHPLACE (City and state or country) <u>BERGER MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>F.W. KALLMEYER</u>			13b. MOTHER'S MAIDEN NAME <u>MARY ERK</u>		14. NAME OF HUSBAND OR WIFE <u>MELLA KALLMEYER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>MRS. MELLA KALLMEYER McKITTRICK Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Chronic backward cardiac failure</u>			DUE TO (c) <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Severe general arteriosclerosis 4500</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
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 <u>8/29/53</u> to <u>11/12/57</u> and last saw her alive on <u>11/12/57</u> Death occurred at <u>1:33 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>W. O. Blumer</u> (Degree or title)				22b. ADDRESS <u>Herrington, Mo</u>		22c. DATE SIGNED <u>11/15/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>11-16-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Big Springs Mo</u>		
24. FUNERAL DIRECTOR'S ADDRESS <u>HOGO H. BLUMER Herrington Mo</u>				25. DATE RECD. BY LOCAL REG. <u>Nov. 15th 1957.</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Eunice Beak</u>	

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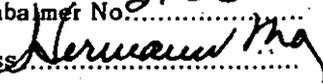
STATEMENT BY LICENSED EMBALMER

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 

Licensed Embalmer No. 3160

P. O. Address 

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.