

Health,
Welfare
Public
Service

300
-57

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009864

STANDARD FILE NUMBER

957

FILED MAR 19 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</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>Calden Age Nursing 2905 Campbell</u> Length of stay in 1b <u>50 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>300 W. 11.3</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>B.</u> Last <u>Callister</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 25, 1872</u>	9. AGE (In years last birthday) <u>86</u>	FUNDER 1 YEAR Months <u>8</u> Days <u>20</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welfare Investigator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>City of K.C., Mo.</u>	11. BIRTHPLACE (City and state or country) <u>Wamego, Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>J. H. Clardy</u>	13b. MOTHER'S MAIDEN NAME <u>Isabelle Bertrand</u>	14. NAME OF HUSBAND OR WIFE <u>W. H. Callister</u>
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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>-</u>	17. INFORMANT Address <u>J. C. Callister, 300 W. 11.3 K.C. Mo.</u>
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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>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Typhoid</u>		<u>3 yrs</u>
	DUE TO (c) <u>Arthritis & senility</u>		<u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>725x</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.) <u>2</u>
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20c. TIME OF INJURY Hour <u>2</u> Month <u>2</u> Day <u>22</u> Year <u>58</u> a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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
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21. I attended the deceased from <u>Sept. 23, 1957</u> to <u>Feb 20, 1958</u> and last saw her ^{him} alive on <u>Feb 20, 1958</u> Death occurred at <u>8:50 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Raymond W. Hanna, D.O.</u>	22b. ADDRESS <u>12007 E. 47th K.C. Mo</u>	22c. DATE SIGNED <u>2/20/58</u>
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23a. BURIAL, CREMATION, EMOVAL (Specify)	23b. DATE <u>2-22-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calden Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Melody - Mc Killip - Eglar F. H. Woodland - K.C. Mo.</u>	25. DATE RECD BY LOCAL REG. <u>2-22-58</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Raymond W. Hanna

Process Sub. to [unclear]
Dr. Raymond Hanna
will sign in A.M.

DL 3-6889

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 *E. C. Gibson*

Licensed Embalmer No. *4137*.....
P. O. *Beckinridge, 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.