

THE DIVISION OF HEALTH OF MISSOURI  
**DIVISION CERTIFICATE OF DEATH**

58-021383

STATE FILE NUMBER

FILED JUL 1 1958 Registration District No. 99 Primary Registration District No. 5376 Registrar's No. 46

1. PLACE OF DEATH a. COUNTY <u>De Kalb</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo 0320</u> b. COUNTY <u>De Kalb</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grandview Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Grandview Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Grandview Township</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>Grandview Township</u>		Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES HUGH CALLAWAY</u>			4. DATE OF DEATH Month Day Year <u>6 21 58</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>1-9-1873</u>		9. AGE (In years last birthday) <u>85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Waverly Mo 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Hugh Callaway</u>		13b. MOTHER'S MAIDEN NAME <u>Eliza Masterson</u>		14. NAME OF HUSBAND OR WIFE <u>Zella Callaway</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>498-42-2069</u>		17. INFORMANT <u>Elvyn Callaway Cameron</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>Arteriosclerotic, hypertensive</u> DUE TO (b) <u>Heart Disease</u> DUE TO (c) <u>decompensation</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a)) <u>4200</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>1946</u> to <u>6-21-58</u> and last saw <sup>him</sup> <u>alive on June 10 1958</u> Death occurred at <u>TO</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>J. H. Cameron MD</u>			22b. ADDRESS <u>Cameron, Mo</u>		22c. DATE SIGNED <u>6-23-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6/24/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ostorn</u>		23d. LOCATION (City, town, or county) (State) <u>Ostorn Mo</u>
24. FUNERAL DIRECTOR <u>Poland Funeral Home</u>		ADDRESS <u>Cameron</u>		25. DATE RECD. BY LOCAL REG. <u>6-26-58</u>	26. REGISTRAR'S SIGNATURE <u>R. Davidson</u>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service  
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 -57  
 3-2-1  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 All diseases in Part I 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 .....

*Robert F. Poland*

Licensed Embalmer No. *4797*

P. O. Address *222 ...*

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.