

r. Health,
& Welfare
b. Public
h Service

Dr. M ddux

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028784

STATE FILE NUMBER

FILED SEP 2 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 826

S. 300
1-57

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SPRINGFIELD
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		Length of stay in 1b 57 YRS.	d. STREET ADDRESS (If outside, give location) 613 E. CATALPA
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First LESLIE Middle G. Last CALL			4. DATE OF DEATH Month AUG. Day 22 Year 1958		
---	--	--	---	--	--

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 APRIL 4 1896	9. AGE (In years last birthday) 62	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, specify if institution) OWNER & OPERATOR, LES	10b. KIND OF BUSINESS OR INDUSTRY CALL ADDING MACHINE CO.	11. BIRTHPLACE (City and state or country) PUEBLO, COLO	12. CITIZEN OF WHAT COUNTRY? USA
--	---	---	--

13a. FATHER'S NAME OSCAR L. CALL	13b. MOTHER'S MAIDEN NAME INGA S. MORRIS	14. NAME OF HUSBAND OR WIFE JULIA CALL
--	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> unknown) (If yes, give year or dates of service) YES W.W. # 1	16. SOCIAL SECURITY NO. 493-36-9819	17. INFORMANT Address MRS. JULIA CALL, SPRINGFIELD, 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) Bronchogenic Carcinoma		INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }
DUE TO (b) **with Metastases to Pleura, Ribs and spine**
DUE TO (c) **1621**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

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.) none
---	---

20c. TIME OF INJURY Hour none Month, Day, Year a.m.

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 SPRINGFIELD	COUNTY GREENE	STATE
--	--	--	-------------------------	-------

21. I attended the deceased from January 1957 to 8-22-58 and last saw ^{her} alive on 8-22-58 Death occurred at 8:25 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W.D. Dandy, M.D.	(Degree or title) 0	22b. ADDRESS 609 Cherry, Springfield, Mo.	22c. DATE SIGNED 8/23/58
---	-------------------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8-25-58	23c. NAME OF CEMETERY OR CREMATORY GREENLAWN	23d. LOCATION (City, town, or county) SPRINGFIELD, MO.
--	-----------------------------	--	--

24. FUNERAL DIRECTOR H.H. LOHMEYER	ADDRESS SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 8-25-58	26. REGISTRAR'S SIGNATURE Offie G. Melton
--	------------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

SEP 1 1958

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 *H. L. McCann*

Licensed Embalmer No. *2727*

P. O. Address *Springfield, 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.