Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-043016
STATE FILE NUMBER

FILED DEC 9 1958 Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 129

1. PLACE OF DEATH
a. COUNTY SULLIVAN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MILAN — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) SULLIVAN CO. MEMORIAL — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY SULLIVAN
c. CITY OR TOWN MILAN — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First JOHN Middle HARVEY Last CALL

4. DATE OF DEATH Month 12 Day 1 Year 1958

5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 9-10-1866

9. AGE (In years last birthday) 92 — IF UNDER 1 YEAR: Months 2 Days 20 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER
10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) SMITH COUNTY, VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME JOHN CALL
13b. MOTHER'S MAIDEN NAME POSTEM
14. NAME OF HUSBAND OR WIFE BELLE CALL Milan Mo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Lona Thomas Address

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 2 years
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) 4222

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 0

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 11-15-58, to 12-1-58 and last saw him alive on 12-1-58
Death occurred at 6:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE V H Robinson (Degree or title) D.O.
22b. ADDRESS Milan, Mo
22c. DATE SIGNED 12-4-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12-4-58
23c. NAME OF CEMETERY OR CREMATORY Oakwood Cem
23d. LOCATION (City, town, or county) Milan (State) Mo.

24. FUNERAL DIRECTOR Schoenes Dwight Schoenes ADDRESS Milan Mo
25. DATE RECD. BY LOCAL REG. 12-5-58
26. REGISTRAR'S SIGNATURE Mrs. M. W. Beckett

(Licensed Embalmer's Statement on Reverse Side)

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.

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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 Dwight Schaene

Licensed Embalmer No. 2667

P. O. Address Milan - 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.