

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002277
STATE FILE NUMBER

Registration District No. 207 Primary Registration District No. _____ Registrar's No. 18

FILED JAN 26 1959

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wodaway</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Taylor</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hopkins Twp</u> | | c. CITY OR TOWN <u>Bedford</u> <u>81408</u> | |
| c. FULL NAME OF HOSPITAL OR INSTITUTION | | d. STREET ADDRESS (If outside, give location) | |
| Length of stay in 1b | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

| | |
|---|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Mathew Franklin McCall</u> | 4. DATE OF DEATH Month Day Year <u>Jan, 13 1959</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>2-27-1886</u> | 9. AGE (In years last birthday) <u>72</u> | IF UNDER 1 YEAR Months <u>10</u> Days <u>16</u> | IF UNDER 24 HRS. Hours <u>3</u> Min. |
|-----------------------|----------------------------------|---|--------------------------------------|--|--|---|

| | | | |
|--|-----------------------------------|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Recreation Parlor Operator</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|--|-----------------------------------|---|---|

| | | |
|---|---|--|
| 13a. FATHER'S NAME <u>James William McCall</u> | 13b. MOTHER'S MAIDEN NAME <u>Nancy Jane Easton</u> | 14. NAME OF HUSBAND OR WIFE <u>Leota McCall</u> |
|---|---|--|

| | | | |
|--|---|---|---------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. <u>491-09-3760</u> | 17. INFORMANT <u>Max Leota McCall Bedford Iowa</u> | Address |
|--|---|---|---------|

| | | |
|--|--|--|
| 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>Fractured Cervical spine</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u> |
| 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) | | |

| | |
|--|---|
| 20a. ACCIDENT <input checked="" 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>run off road in fog + hit buttment of bridge</u> |
|--|---|

| | | | | | |
|---|---|--|--|--------------------------|--------------------------|
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>State Math of Hopkins</u> | 20f. CITY, TOWN, OR LOCATION <u>Hopkins</u> | COUNTY <u>Wodaway</u> | STATE <u>Missouri</u> |
|---|---|--|--|--------------------------|--------------------------|

| | | | |
|---|--|---------------------------------------|------------------------------------|
| 21. I attended the deceased from Death occurred at <u>6:30</u> P. on <u>1/13/59</u> and last saw her/him alive on _____ | 22a. SIGNATURE (Degree or title) <u>D. P. Byland M.D.</u> | 22b. ADDRESS <u>Marionville MO</u> | 22c. DATE SIGNED <u>1/17/59</u> |
|---|--|---------------------------------------|------------------------------------|

| | | | |
|--|---------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Jan-16-1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Athelstan Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Athelstan Iowa</u> |
|--|---------------------------------|---|--|

| | | | |
|---|--------------------------------|--|---|
| 24. FUNERAL DIRECTOR <u>Floyd E Shum</u> | ADDRESS <u>Bedford Iowa</u> | 25. DATE RECD. BY LOCAL REG. <u>1 21 59</u> | 26. REGISTRAR'S SIGNATURE <u>Bess Holt</u> |
|---|--------------------------------|--|---|

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FEB 24 1959

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^{ie}....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Floyd E. Shum*.....

Licensed Embalmer No. 2381 Iowa
P. O. Address Bedford Iowa....

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.