

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017640

STATE FILE NO. 2088

FILED MAY 21 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2088

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence Before Admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V. A HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>1632 1/2 East 18th St.</b>	
Lenght of stay <b>12 DAY</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>NMI</b> Last <b>CALLOWAY</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-31-1900</b>
9. AGE (In years of birthday) <b>58</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Little Rock, Arkansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Pete Calloway</b>		13b. MOTHER'S MAIDEN NAME <b>Sally Mackbroom</b>	14. NAME OF HUSBAND OR WIFE <b>Collie Calloway</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes 6-27-42 to 6-29-43</b>		16. SOCIAL SECURITY NO. <b>486-01-5232</b>	17. INFORMANT Address <b>Official records VA HOSPITAL, K.G., MO.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary congestion and edema</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Bilateral apical pulmonary tuberculosis with cavitation and tuberculous pneumonia, right upper lobe</b>			
DUE TO (c) <b>Carcinoma of prostate with extensive bony metastasis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>002XH</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK <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. Attended the deceased from <b>April 13, 1959</b> to <b>April 25, 1959</b> Death occurred at <b>10:30</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>W. Williams</i> M.D.		22b. ADDRESS <b>N.A. Hoop.</b>	22c. DATE SIGNED <b>4-27-59</b>
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-29-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>FT. Leavenworth, Kansas</b>
24. FUNERAL DIRECTOR ADDRESS <b>Mrs. Meek's Mortuary K.C. Mo</b>		25. DATE RECD. BY LOCAL REG. <b>4-27-59</b>	26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>

A. J. Williams USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



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 *Millard B. Paske*

Licensed Embalmer No. *5013*

P. O. Address *A. C. M.*

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.