URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 14 1959

59-043177
STATE FILE NUMBER

Registration District No. 373 Primary Registration District No. 6269 Registrar's No. 49

1. PLACE OF DEATH
a. COUNTY WEBSTER
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural- Home Ozark — Length of stay in 1b Life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION At Home on Rt. 4. — Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY WEBSTER
c. CITY OR TOWN MARSHFIELD — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS Rt. 4 6 mi SOUTH (If outside, give location) — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First JOHN Middle M Last CALLAWAY
4. DATE OF DEATH Month NOV Day 30 Year 1959
5. SEX MALE
6. COLOR OR RACE WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 4-27-1884
9. AGE (last birthday) 75
IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME JOHN A. CALLAWAY
13b. MOTHER'S MAIDEN NAME NANCY HAYMES
14. NAME OF ~~HUSBAND OR~~ WIFE JEANETTE
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. 498-28-0495
17. INFORMANT JEANETTE CALLAWAY Address MARSHFIELD

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) Coronary Occlusion, Acute — INTERVAL BETWEEN ONSET AND DEATH 15 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis, Coronary
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
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 November 30, 1959 to Nov. 30, 1959 and last saw ~~her~~ him alive on Nov. 30, 1959
Death occurred at 5:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C.P. MacDonald (Degree or title) M.D.
22b. ADDRESS Marshfield, Mo.
22c. DATE SIGNED 12/2/59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 12-3-1959
23c. NAME OF CEMETERY OR CREMATORY EBENEZER
23d. LOCATION (City, town, or county) WEBSTER Co (State) MO

24. FUNERAL DIRECTOR BARBER-EDWARDS MARSHFIELD ADDRESS
25. DATE RECD. BY LOCAL REG. 12-7-59
26. REGISTRAR'S SIGNATURE J. Francis

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed George Stapp

Licensed Embalmer No. 3161

P. O. Address Mt. Grove, T

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.