URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-007689
STATE FILE NUMBER

FILED VS FEB 29 1960 Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 46

ENDED

1. PLACE OF DEATH
a. COUNTY: RANDOLPH
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: MOBERLY
Length of stay in 1b: 2½ DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: WOODLAND HOSP.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO. b. COUNTY: MONROE
c. CITY OR TOWN: R.F.D. HOLLIDAY, MO. Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 2 MI. N. HOLLIDAY MO. Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First DORA Middle MAE Last CALLISON
4. DATE OF DEATH: Month FEB. Day 13 Year 1960
5. SEX: F
6. COLOR OR RACE: W
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 8/8/1886
9. AGE (last birthday): 74
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): DOMESTIC
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEHOLD WORKER
11. BIRTHPLACE (City and state or country): MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: CHARLES T. STUART
13b. MOTHER'S MAIDEN NAME: SALLY OXLEY
14. NAME OF HUSBAND OR WIFE: GUY A. CALLISON
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.: 497-30-8060
17. INFORMANT: PAUL CALLISON Address: R.F.D. #1 HOLLIDAY

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): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week
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)
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 Feb. 11, 1960, to Feb. 13, 1960 and last saw her alive on Feb. 13, 1960
Death occurred at 12:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF

22a. SIGNATURE (Degree or title): Will Henry, M.D.
22b. ADDRESS: Moberly, Mo.
22c. DATE SIGNED: 2-16-60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: FEB. 15-1960
23c. NAME OF CEMETERY OR CREMATORY: BETHEL CEM.
23d. LOCATION (City, town, or county) (State): HOLLIDAY MO.

24. FUNERAL DIRECTOR ADDRESS: E.H. AGNEW PARIS, MO.
25. DATE RECD. BY LOCAL REG.: 2-15-60
26. REGISTRAR'S SIGNATURE: [illegible]

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed E. H. Agnew,
Signature of Student Embalmer

Licensed Embalmer No. 4000

P. O. Address Paris, M

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.