

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-031726

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 180

FILED SEP 5 1962	
1. PLACE OF DEATH a. COUNTY <u>Livingston</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u> Length of stay in 1b <u>10 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1208 Webster</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u> c. CITY OR TOWN <u>Lawson</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Converse Township</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED First Middle Last <u>Leroy Christian Callaway</u>	
4. DATE OF DEATH Month Day Year <u>August 28, 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-1886</u>
9. AGE (last birthday) <u>75</u>	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) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) <u>Eversonville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Benjamin Callaway</u>	13b. MOTHER'S MAIDEN NAME <u>Katherine Schoess</u>
14. NAME OF HUSBAND OR WIFE <u>Norah Ann Clowdis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	17. INFORMANT Address <u>Lowell L. Callaway; Lawson, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerosis, Hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input 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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
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. I attended the deceased from <u>Aug 23-1962</u> to <u>Aug 28-1962</u> and last saw him ^{here} alive on <u>Aug 27-1962</u> Death occurred at <u>eleven fifteen p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>Chillicothe Mo</u>
22c. DATE SIGNED <u>8-29-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-30-62</u>
23c. NAME OF CEMETERY OR CREMATORY <u>I. O. O. F.</u>	23d. LOCATION (City, town, or county) (State) <u>Linneus, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Norman Funeral Home Chillicothe, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 29, 1962</u>
26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>	

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 Elton F. Newman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, 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.

Date Taken To Dr. Ellis 8/29/62
Recd. 8/29/62

ELLIS