

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

30153

1927

1. PLACE OF DEATH

County Jenny
Towship
City Windsor (No.)

Registration District No. 14
Primary Registration District No. 4211

File No.
Registered No. 24
St. Ward

2. FULL NAME

Rena Diamond Callison

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 11 - 1885

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
42 9 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Windsor (STATE OR COUNTRY) Mo.

10. NAME OF FATHER John M. Kiddion

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Maitha Gallard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT (Address) Mrs. Dore Boych
Windsor Mo.

15. FILED Oct 18 1927 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 16 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1927, to Oct 16, 1927, that I last saw h. or alive on Oct 16, 1927, and that death occurred, on the date stated above, at 10-45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Spurorrhage from uterine fibroid tumor

548 (duration) yrs. mos. 7 da.
1200 CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? Yes DATE OF Oct 16 1927

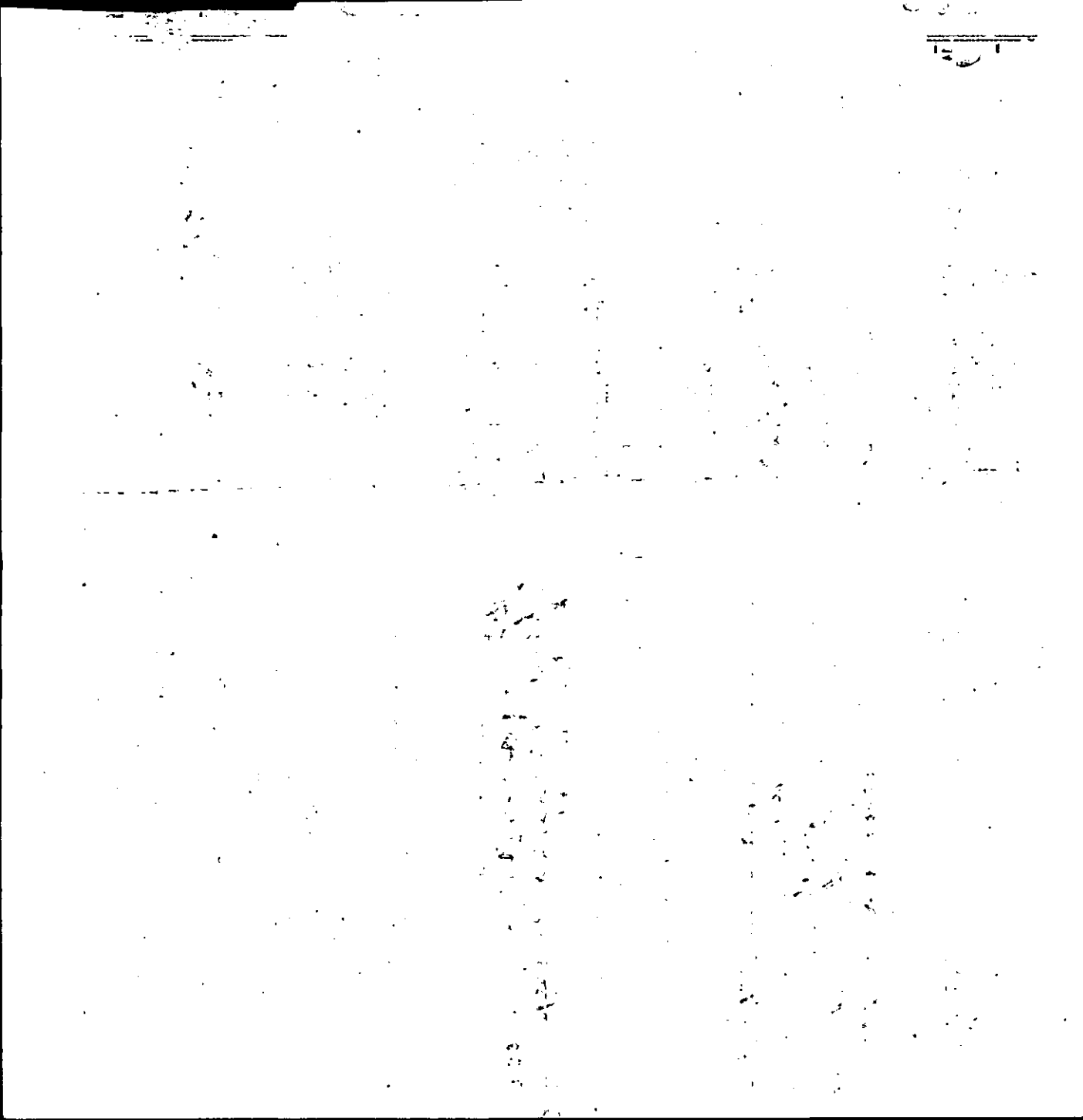
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Examined
(Signed) T. E. Moffet M.D.
1849, 1927 (Address) Windsor Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Windsor Mo. DATE OF BURIAL Oct 18 1927

20. UNDERTAKER W. E. Heston ADDRESS Windsor Mo.



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION REQUESTED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Henry
Township
City Windsor (No., St. Ward)

Registration District No. 14
Primary Registration District No. 4211

File No. 30153
Registered No. 24

2. FULL NAME

Reena Diamond Callison

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
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5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14.

INFORMANT
(Address)

15.

FILED 19.....

D. Jennings
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 16 - 19 27

17. I HEREBY CERTIFY, That I attended deceased from to 19.....
(that I last saw h. alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart failure from uterine fibroid tumor, malignant

..... (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

PHYSICIANS should state at once if PATIENT is very important. EXACT INFORMATION should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. EXACT STATE SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED.

SUPPLEMENTARY

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