3 MAY 24 1929

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

Do not use this space.

14281

1. PLACE OF DEATH

County: Dent — Registration District No.: 266 — File No.:

Township: ~~Springcreek~~ — Primary Registration District No.: X164 — Registered No.: 5-1

City: Salem Mo. (No. ..... St. ..... Ward)

2. FULL NAME Carmmon Faye Callahan

(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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 6 1929

7. AGE: Years ---- Months --- Days -- If LESS than 1 day, 16 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): Salem
(STATE OR COUNTRY): Mo.

PARENTS

10. NAME OF FATHER: Carl Callahan
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Dent Co.
(STATE OR COUNTRY): Mo.
12. MAIDEN NAME OF MOTHER: Gertie Hubbs
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Dent Co.
(STATE OR COUNTRY): Mo.

14. INFORMANT: Mrs Hubbs
(Address): Salem Mo.

15. FILED 4/7 1929. H. E. Rudd, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April 6 1929

17. I HEREBY CERTIFY, That I attended deceased from April 6, 1929, to April 6, 1929, that I last saw her alive on April 6, 1929, and that death occurred, on the date stated above, at 9 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hydro Cephalic

157A

159A

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY) .....

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) H. G. Dillon, M.D.

, 19 (Address) Salem 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: Green Forrest Cemetary — DATE OF BURIAL: 4/7 1929

20. UNDERTAKER: Carl Spencer — ADDRESS: Salem Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.