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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MAY 15 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16375

Registration District No. 875 Primary Registration District No. 6162 Registrar's No. 111

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Rural Washington Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3 blocks South of Nevada City Limits
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 70 yrs. (Specify whether years, months or days)

8. (a) PRINT FULL NAME Frank Boone Calloway.

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lida Calloway

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec. 8 1862 (Month) (Day) (Year)

8. AGE: Years 77 Months 4 Days 3. If less than one day hr. min.

9. Birthplace St. Charles Co. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Retired.

11. Industry or business

MOTHER FATHER

12. Name Dr. J. B. Calloway.

13. Birthplace St. Charles Co. (City, town, or county) Mo. (State or foreign country)

14. Maiden name Letitia Logan

15. Birthplace St. Charles Co. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Alto H. Calloway

(b) Address Nevada Mo R.R. #1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/40 (Month) (Day) (Year)

(c) Place: burial or cremation Newton Burial Park

18. (a) Signature of funeral director Eichinger Funeral Home

(b) Address Nevada Mo.

19. (a) 4/13/40 (Date received local registrar) (b) Allen V. Hays (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon

(c) City or town Nevada Rural (If outside city or town limits, write "RURAL")

(d) Street No. Washington Township (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11 year 1940 hour 7 PM minute M.

21. I hereby certify that I attended the deceased from March 25, 1940 to April 11, 1940 that I last saw him alive on 4/11, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage following cerebral thrombosis of 1 year

Due to Bronchopneumonia secondary

Due to

Other conditions (Include pregnancy within 3 months of death) Gangrene

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. M. Yates (M. D. or other)

Address Nevada Date signed 4/14/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 5-40-229
Date Filed 5-6-40

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Mark Eichinger

Licensed Embalmer No. 26156

P. O. Address Nevada, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.