

No. 2  
1-10-39  
17-39  
X-21492

38632

DEC 11 1940 90

Primary Registration District No. 5408

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Dunklin Salem  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin  
(c) City or town Rural  
(If outside city or town limit, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME John Samuel Callahan  
8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH, Month Oct day 6  
year 1940 hour 4 minute a. M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept. 23 - 1940  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 4 1940 to Oct 6 1940.  
that I last saw him alive on Oct 5 1940.  
and that death occurred on the date and hour stated above.

8. AGE: Years \_\_\_\_\_ Months 13 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Heart Failure - Rheumatism  
2 Days  
Duration

9. Birthplace Dunklin Mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Infant

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name J. D. Callahan  
18. Birthplace Cairo, Tenn.  
(City, town, or county) (State or foreign country)  
14. Maiden name Ella Shields  
15. Birthplace Cairo, Tenn.  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Allen Shields  
(b) Address Beruth, Mo.  
17. (a) Burial (b) Date thereof Oct-7-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation McBrew  
18. (a) Signature of funeral director McDaniel Funeral Home  
(b) Address Beruth, Mo.  
19. (a) Nov. 7 - 1940 (b) A. D. McDaniel  
(Date received local registrar) (Registrar's signature)

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 H. H. Bide (M. D. or other) \_\_\_\_\_  
Address Beruth Mo. Date signed 10-6-40

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

RECEIVED

District Health Officer No.

District File Number 1240-180

Date Recd 12/9/4

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**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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