

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 2001

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

9
3
6

1. PLACE OF DEATH: **Greene**
(a) County **Springfield**
(b) City or town **Springfield**
(c) Name of hospital or institution **1140 N. Clay**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **54 Years**
In this community **54 Years**
(Specify whether years, months or days) **2**

3. (a) PRINT FULL NAME **William C. Calland**
3. (b) If veteran, name war **Civil War** 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 **Josephine Calland** 6. (c) Age of husband or wife if alive **82** years
7. Birth date of deceased **December 27 1844**
(Month) (Day) (Year)

8. AGE: Years **95** Months **11** Days **5** If less than one day hr. min.

9. Birthplace **Summerfield Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**
11. Industry or business **College Professor**

MOTHER FATHER { 12. Name **William Calland** 7
13. Birthplace **Unknown Scotland**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Josephine Calland**
(b) Address **Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **Dec. 4 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Maple Park**

18. (a) Signature of funeral director **H.H. Lohmeyer**
(b) Address **Springfield, Mo.**

19. (a) **12-4-40** (b) **W. E. Handley md**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Greene**
(c) City or town **Springfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **1140 N. Clay**
(If rural, give location) **0**
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec.** day **2**
year **1940** hour **2** minute **p.** M.

21. I hereby certify that I attended the deceased from **June**, 19**40**, to **Dec 2**, 19**40**,
that I last saw him alive on **Dec 2, 40**, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **Renal Failure (anuria)**

Due to **Bacterial infection (Staphylococcus) and 5/2**
Due to **retention**

Other conditions **carcinoma - feet**
(Include pregnancy within 3 months of death)
auricular since 3/21/38

Major findings:
Of operations **none**
Of autopsy **none**

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?
981 (Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature **W. E. Handley** (M. D. or other) **1**
Address **Hallway St. Springfield** Date signed **12/3/40**

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.....

....., 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, fact should be so stated above.

