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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED FEB 14 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. E.E. Glenn

State File No. 2623

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 70

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

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: St. John Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)

In this community 5 days

3. (a) PRINT FULL NAME Mrs. Kate Callahan

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced 2 divorced Widowed

6. (b) Name of husband or wife Will Callahan

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

7. Birth date of deceased: Sept. 25 1858
(Month) (Day) (Year)

8. AGE: Years 82 Months 4 Days 0 If less than one day hr. min.

9. Birthplace Unknown 4 Ireland
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business Home

MOTHER FATHER

12. Name Daniel Gillespie

13. Birthplace Unknown 4 Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Mary Hegerly

15. Birthplace Unknown 4 Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Maurice Gillespie

(b) Address Cotter, Arkansas

17. (a) Burial (b) Date thereof Jan. 27 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo. 65811

19. (a) 1-27-41 (b) W.E. Naudley MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Baxter

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

(d) Street No. _____ (If rural, give location) 2

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 25 year 1941 hour 5 minute 18 a.m.

21. I hereby certify that I attended the deceased from Jan 20, 1941, to Jan 25, 1941 that I last saw her alive on Jan 24, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial Failure
Classic myocarditis
Hyper tension

Due to _____

Due to _____

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

Major findings: Of operations: _____

Of autopsy: not done

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? _____

While at work? _____ (Specify type of place)

Means of injury _____

Signature _____ (M. D. or other) A

Address Springfield, Mo Date signed 1-27-41

Duration 5 wks

3 yd.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 *L. Debra Gorman*

Licensed Embalmer No. *3177*

P. O. Address *Peruville, Mo*

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.

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