

No. 2  
4-12-40  
-17-39  
X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34392  
Registrar's No. 1011

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH  
(a) County BUCHANAN  
(b) City or town ST. JOSEPH  
(c) Name of hospital or institution: STATE HOSPITAL No. 2  
(d) Length of stay: In hospital or institution 3 yrs. 9 months  
In this community 3 yrs. 17 days 9 mos.

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Andrew  
(c) City or town Bolckow  
(d) Street No. R. F. D. #2  
(e) If foreign born, how long in U. S. A.? native years.

3. (a) PRINT FULL NAME Sarah Belle Callahan  
(b) If veteran, name war none  
(c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct. day 21  
year 1941 hour 12:50 minute A.M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widow  
(b) Name of husband or wife N. B. Callahan  
(c) Age of husband or wife if alive deceased years  
7. Birth date of deceased (Month) ? (Day) ? (Year) 1859

21. I hereby certify that I attended the deceased from March 17, 1941 to Oct 21, 1941; that I last saw her alive on Oct 21, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia unresolved Duration 2 wks

8. AGE: Years 82 Months 9 Days 24 If less than one day hr. min.

Due to arteriosclerotic heart disease Definite

9. Birthplace Indiana (City, town, or county) (State or foreign country)  
10. Usual occupation none  
11. Industry or business none

Other conditions Senility  
Major findings: Of operations none  
Of autopsy none 107

MOTHER FATHER  
12. Name unk  
13. Birthplace Indiana (City, town, or county) (State or foreign country)  
14. Maiden name unk  
15. Birthplace unk (City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mo. State Hosp #2 records  
(b) Address St. Joseph Mo.  
17. (a) Buried (b) Date thereof 10-24-41  
(c) Place: burial or cremation Whitesville

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) (e) Means of injury

18. (a) Signature of funeral director H. G. Taggart  
(b) Address St. Joseph Mo.  
19. (a) 10/21/41 (Date received local registrar) (b) H. G. Taggart (Registrar's signature)

23. Signature Donald Breit (M. D. or other) M.D.  
Address Mo. State Hosp #2 Date signed 10-22-41

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

**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

*R. G. Taggart*

Licensed Embalmer No.

*2563*

P. O. Address

*King City 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.**