

S. No. 2
FM-2-43
7-5-17-39
K35697

24913

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 30 1945
Registration District No. _____

Primary Registration District No. 6076

Registrar's No. 1837

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Manchester Nursing Home 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 months
(Specify whether

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike 82

(c) City or town Louisiana 2
(If outside city or town limits, write "RURAL")

(d) Street No. 1403 South Carolina 1
(If rural, give location)

(e) Citizen of foreign country? yes (Yes or No) 1

If yes, name country _____

3. (a) PRINT FULL NAME Ralph Chilton Callaway

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color of hair White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased October 9 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

9 7 hr. _____ min.

9. Birthplace LOUISIANA MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation Med

MOTHER FATHER

11. Industry or business _____

12. Name Ralph Ross Callaway

13. Birthplace Glabeery Masowki
(City, town, or county) (State or foreign country)

14. Maiden name Dema Manly

15. Birthplace Pleasant Hill Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Dema Callaway

(b) Address 1403 South Carolina St

17. (a) REMOVED (b) Date thereof 7-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LOUISIANA MP

18. (a) Signature of funeral director BAUMANN BROTHERS

(b) Address OVERLAND MO

19. (a) 7-23-45 (b) E. S. Dr. Garand
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 16
year 45 hour 9 minute P M.

21. I hereby certify that I attended the deceased from March 17
1945 to July 16 1945

that I last saw him alive on July 16 1945
and that death occurred on the date and hour stated above.

Immediate cause of death congestional hydrocephalus

Duration _____

Due to 157a

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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? _____ (a) Means of injury _____

23. Signature A. J. Madlin Jr (M. D. or other) 0

Address 3507 Potomac Date signed 7-18-45

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

AUG 23 1945

100 100 45

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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address Overland 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.