

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **7377**  
Registrar's No. **342**

**FILED APR 7 1952**  
BIRTH NO. \_\_\_\_\_

REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2322 Bartlett St.</b>		d. STREET ADDRESS (If rural, give location) <b>2322 Bartlett St.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Claude</b> b. (Middle) <b>Milnot</b> c. (Last) <b>Callicotte</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>March 27, 1952</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>December 27, 1875</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret. flagman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Clarinda, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Robert E. Callicotte</b>		13b. MOTHER'S MAIDEN NAME <b>Phoebe C. Simonton</b>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unk.</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Miss Nelle Callicotte, 2322 Bartlett, St. Joseph, Mo.</b>	

18. CAUSE OF DEATH Enter only one cause per line for (B), (C), and (e)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Cerebral Hemorrhages, General Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <b>331X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **Sept. 1, 1951** to **Mar 26, 1952**, that I last saw the deceased alive on **Mar 26, 1952**, and that death occurred at **8:40a. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>H F Mundy M.D.</b>		23b. ADDRESS <b>St Joseph Mo</b>		23c. DATE SIGNED <b>3/27/52</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>3/29/1952</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Mora</b>	24d. LOCATION (City, town, or county) (State) <b>St. Joseph Missouri</b>	

DATE REC'D BY LOCAL REG. <b>Apr 12, 1952</b>	REGISTRAR'S SIGNATURE <b>Carl C. Casper</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Newton Bowman</b>	ADDRESS <b>Funeral Home St. Joseph Mo</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

S. No. 300  
V. 10.48

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APR 11 1930

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed William Spalding

Licensed Embalmer No. 4535

P. O. Address 319 S. 11th St. Des Moines

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.