

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-019987
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2867

FILED JUN 3 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT
1			
2 <u>3188</u>			
3			
4 <u>1</u>			
5 <u>2</u>			
6			
7 <u>0</u>			
8 <u>2</u>			
9 <u>9572.2</u>			
10			
11			
12 <u>62-2</u>			
13			
ITEM NO.	SHOULD READ	BY AFFIDAVIT OF	FRANK E. Day, M.D.

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 38 YRS.	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION NORTHEAST OSTEOPATHIC HOSP.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 606 BENTON BLVD. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNA Middle ELIZABETH Last CALLAHAN			4. DATE OF DEATH Month 5 Day 20 Year 1963
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/12/1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (last birthday) 65 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
11. BIRTHPLACE (City and state or country) POLK COUNTY MISSOURI		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME GEORGE W. ANDERSON		13b. MOTHER'S MAIDEN NAME SARAH FRANCES WARE	14. NAME OF HUSBAND OR WIFE TIMOTHY P. CALLAHAN Address MO.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	17. INFORMANT VIRGIL ANDERSON 720 W. MAPLE INDEPENDENCE,
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO (b) Ulcerative Colitis & Hemorrhage? DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I (a) Colectomy (surgery)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
21. I attended the deceased from <u>May 4, 1963</u> to <u>May 20, 1963</u> and last saw her alive on <u>May 19, 1963</u> Death occurred at <u>3 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Frank E. Day M.D.		22b. ADDRESS 4314 E 9th. St. KCMO	22c. DATE SIGNED 5-20-63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5-22-63	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET	23d. LOCATION (City, town, or county) KANSAS CITY, MISSOURI (State)
24. FUNERAL DIRECTOR H. Blackman & Son Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 5-20-63	26. REGISTRAR'S SIGNATURE Ruth Long

USE BLACK INK OR TYPEWRITER RIBBON

4314 E 9th
Apt 1-0162

1-2-8
1-8
0-8
6-80

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,

by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Hubert B. Baird

Licensed Embalmer No. 4888

P.O. Address TC 24 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.