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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED OCT. 13 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29420

State File No. \_\_\_\_\_

Registration District No. 118

Primary Registration District No. 4190

Registrar's No. 7

1. PLACE OF DEATH:  
(a) County Gasconade.  
(b) City or town Bland.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: R.F.D.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None. (Specify whether  
In this community 2 weeks.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Francis  
(c) City or town Cantwell  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country X

3. (a) PRINT FULL NAME Robert B. McCall  
3. (b) If veteran, name war World War No. 2  
3. (c) Social Security No. 493-05-0871

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 10-5 day 1948  
year \_\_\_\_\_ hour 12-34 minute 33 M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_  
that I last saw h. \_\_\_\_\_ alive on expired  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Loretta McCall  
6. (c) Age of husband or wife if alive 30 years  
7. Birth date of deceased July 14th 1906  
(Month) (Day) (Year)

Immediate cause of death Electrocution by live wire  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years 42 Months 2 Days 29  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace Bonne Terre, Missouri, MO  
(City, town, or county) (State or foreign country)

10. Usual occupation Lineman.

11. Industry or business X

MOTHER FATHER { 12. Name William McCall,  
13. Birthplace Unknown, Missouri, MO  
(City, town, or county) (State or foreign country)  
14. Maiden name Angeline David,  
15. Birthplace Bonne Terre, Missouri, MO  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Loretta E. McCall  
(b) Address Cantwell, Mo.

17. (a) Burial (b) Date thereof Oct. 8, 1948.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Desloge, Mo.

18. (a) Signature of funeral director Neuburg & Ditty Inc.

(b) Address Washington, Mo.

19. (a) Oct. 5, 1948 (b) Dorothy Neuburg  
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury X

23. Signature C. A. Bural (M. D. or other) \_\_\_\_\_  
Address Bland, Mo Date signed 10-5-48

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
DISTRICT CLERK IN CHARGE  
DISTRICT FILE NUMBER  
Date Filed  
OCT 12 1948

**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 *A. P. Hilberg*  
Licensed Embalmer No. 2387  
P. O. Address Washington, 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.**

Registration District No. 118 Primary Registration District No. 4190

1. PLACE OF DEATH:

(a) County Lascano  
(b) City or town Blanch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Robert B. McCall

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased July 14 1908  
(Month) (Day) (Year)

8. AGE: Years 2 Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1908 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

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) accident

(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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

NOV 3 1948

S-29420

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