

REC'D NOV 16 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

33672
Do not use this space.

791

1003

8658

1. PLACE OF DEATH

(a) County Registration District No.
 (b) Township Primary Registration District No.
 (c) City Saint Louis, (d) Street No. H.G. Phillips Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Inez Calvin

(a) Residence, No. 4212 West Ashland Avenue St. 10 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) November 19, 1923

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
14 10 12

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Student
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Indianola
 (STATE OR COUNTRY) Mississippi

FATHER 13. NAME Lank Calvin
 14. BIRTHPLACE (CITY OR TOWN) Vicksburg
 (STATE OR COUNTRY) Mississippi

MOTHER 15. MAIDEN NAME Edna Gilkey
 16. BIRTHPLACE (CITY OR TOWN) Unavailable
 (STATE OR COUNTRY) Mississippi

17. INFORMANT Edna Calvin
 (ADDRESS) 4212 West Ashland Avenue

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE Oct 5, 1938

19. FUNERAL DIRECTOR (NAME) Chas. J. Gales
 (ADDRESS) 4107 Finney Avenue

20. FILED OCT 3 1938 J. J. Bredek Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 1, 1938

22. I HEREBY CERTIFY, That I attended deceased from 19....., to..... 19.....
 I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at 1:55 A.M.
 The principal cause of death and related causes of importance were as follows:

Date of onset
Bacterial Endocarditis
 Other contributory causes of importance: 9/a

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease of injury in any way related to occupation of deceased? Y
 If so, specify Alph. H. Perry
 (Signed) Alph. H. Perry
 (Address) 2300 Clark Avenue

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

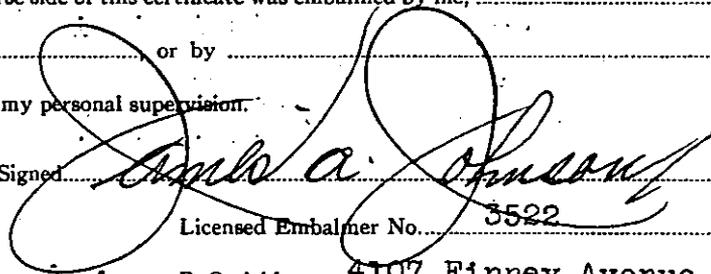
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

James A. Johnson

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed



Licensed Embalmer No. 3522

P. O. Address 4107 Finney Avenue

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, above space should be left blank.