SEP 5 1940 Ca2522

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29664

Registration District No. 784 — Primary Registration District No. 001 — Registrar's No. 1580

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: St. Mary's (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County .....

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. Coronado Hotel (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Robert Anderson Calvin 415

3. (b) If veteran, name war .....

3. (c) Social Security No. 318-10-6275

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Divourced

6. (b) Name of husband or wife Adelaide

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased January 6, 1879 (Month) (Day) (Year)

8. AGE: Years 61 Months 7 Days 12 If less than one day ..... hr. ..... min.

9. Birthplace Youngstown, Ohio. (City, town, or county) (State or foreign country)

10. Usual occupation Asst. To Pres. American Creasoting Co.

11. Industry or business .....

FATHER
12. Name Gustavus Calvin,
13. Birthplace ? (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Mary ?
15. Birthplace ? (City, town, or county) 9 (State or foreign country)

16. (a) Informant J. E. Peterson,

(b) Address 3745 Lindell Blvd.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/19/40 (Month) (Day) (Year)

(c) Place: burial or cremation Belmont Cemetery, Youngstown, Ohio.

18. (a) Signature of funeral director [signature]

(b) Address Clayton Rd. at Concordia Lane.

19. (a) AUG 19 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18, year 1940 hour 3 minute 47 A. M.

21. I hereby certify that I attended the deceased from August 11, 1940, to August 18, 1940; that I last saw him alive on August 17, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Toxemia and Exhaustion	5 days
Due to Ischio-Rectal abscess with extension to scrotum	12 days
Due to Rectal Fistula	4 years
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Ischio-Rectal abscess with extension to scrotum.

Of autopsy Cirrhosis of liver - Lung adhesions right side.

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? ..... (e) Means of injury .....

23. Signature Wm. H. Norton (M. D. or other)

Address Mo. Theater Bldg. Date signed 8/18/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 1994

P. O. Address St. Louis.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.