

FILED APR 20 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12618

State File No.

3463

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2 City Sanitarium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 mos. 17 ds.  
(Specify whether  
In this community 47 yrs.  
years, months or days)

3. (a) PRINT FULL NAME

JOSEPH CALVERT

3. (b) If veteran,

name war World War 1.

3. (c) Social Security

No.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Sgl.

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

7. Birth date of deceased May 6, 1896  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
47 11 8 hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Bricklayer

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

MOTHER FATHER { 12. Name William Calvert  
13. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Katherine Maher  
15. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Thelma Singler  
(b) Address 5400 Arsenal St.

17. (a) Burial (b) Date thereof 4/17/44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Sullivan Bro's  
(b) Address 2849 N. Euclid ave.

19. (a) APR 14 1944 (b) J. Medek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL") 96  
(d) Street No. 4721a St. Louis Ave  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14,  
year 1944 hour 1.45 minute a. M.

21. I hereby certify that I attended the deceased from 1943 to April 14, 1944  
that I last saw him alive on April 14, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis 11943x

Due to Chronic hepatic Cirrhosis  
Due to Paresis 1943x

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 30  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_

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 plane) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature John Joseph Bowlish (M. D. or other)  
Address 5400 Arsenal St. Date signed 4/14/44

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

**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.....

.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed

*Eugene W. Dillman*

Licensed Embalmer No. *2930*

P. O. Address *St. Louis 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.**