

S. No. 2
DM-5-43
v. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34405**
4305
Registrar's No.

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3504 Smart St., K. C. Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community **5 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson** **48**
(c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL")
(d) Street No. **3504 Smart Street** **8**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Rule Louise CALVERT**
(b) If veteran, name war **No**
(c) Social Security No. **None**
(d) Sex **Female**
(e) Color or race **White**
(f) (a) Single, widowed, married, divorced **Single**
(b) Name of husband or wife _____
(c) Age of husband or wife if alive _____ years
(g) Birth date of deceased **July 29th, 1941**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **11**
year **1947** hour **10** minute **0** M.
21. I hereby certify that I attended the deceased from **June**
1945, to **Oct 11, 1947**
that I last saw her alive on **Oct 11**, 19**47**
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

8. AGE: Years Months Days If less than one day
36 **2** **12** hr. min.
9. Birthplace **Boone County Missouri**
(City, town, or county) (State or foreign country)

Due to **influenza in** **1945**
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations **no 93 d**
Of autopsy **no**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
11. Industry or business _____
12. Name **Andrew J. Calvert**
13. Birthplace **Howard County Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Margaret Campbell**
15. Birthplace **Howard County Missouri**
(City, town, or county) (State or foreign country)
16. (a) Informant **Andrew J. Calvert, Father,**
(b) Address **3504 Smart St., K.C. Mo.**
17. (a) **Funeral** (b) Date thereof **10/14/47.**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **New Franklin, MO.**
18. (a) Signature of funeral director **Melody-McGilley-Eylar**
(b) Address **Kansas City, Missouri**
19. (a) **10-13-47** (b) **Sheraldine Holmes**
(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) _____
(e) Means of injury **0**
23. Signature **W. P. Casebolt** (M. D. or other) _____
Address **4000 Baltimore St. E. Mo. 19/12/47**

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

Wm. J. Carter
Registered Apprentice No. *100*
working under my personal supervision.

Signed

Wm. J. Carter
Licensed Embalmer No. *2095*

P. O. Address *156*

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.