

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 9875

2728

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		17			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3930 Enright Avenue</b>				d. STREET ADDRESS (If rural, give location) <b>3930 Enright Ave. Apt 12</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Henry</b> b. (Middle) <b>G.</b> c. (Last) <b>Calloway</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>3 - 24 - 1949</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Aug. 30, 1884</b>			
9. AGE (In years last birthday) <b>64</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>24</b>		IF UNDER 11 HRS. Hours <b></b> Min. <b></b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <b>Wentzville, Missouri</b>			
12. CITIZEN OF WHAT COUNTRY? _____			13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Charlotte Calloway</b>		14. NAME OF HUSBAND OR WIFE <b>Carrie Calloway</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>498-10-7084</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Carrie Calloway 3930 Enright Ave</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac Disease</b> ANTECEDENT CAUSES <b>Cardiac Decompensation</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>W-AS</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <b>March 20, 1949</b> , to <b>March 24, 1949</b> , that I last saw the deceased alive on <b>March 23, 1949</b> , and that death occurred at <b>8:30 a.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>Wassell M. D.</b> (Degree or title) _____				23b. ADDRESS <b>4270 St. Finney St.</b>		23c. DATE SIGNED <b>3-25-49</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <b>3-28-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis</b>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>APR 23 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Lasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>J. H. Randie &amp; Son</b>		ADDRESS <b>2122 Bell Ave.</b>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.

Student .....  
Student Embalmer

Student Embalmer No. \_\_\_\_\_

Signed \_\_\_\_\_

*S J Watson*

Licensed Embalmer No. \_\_\_\_\_

*2698*

P. O. Address \_\_\_\_\_

*2769 Chant*

**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.