

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17951

State File No.

731

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>Meadville</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>7y-9m-21da</u>		e. STREET ADDRESS (If rural, give location) <u>05-80 1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #2,</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u> b. (Middle) <u>CALVIN</u> c. (Last) <u>CALVIN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 28, 1954</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>June 24, 1885</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Chillicothe, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>George Calvin</u>	13b. MOTHER'S MAIDEN NAME <u>Lavonia Hunt</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>John Clavin, Meadville, Mo.</u>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>331 X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 Apr 27, 19 48, to June 27, 19 54 that I last saw the deceased alive on June 27, 19 54 and that death occurred at 5:25A m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. H. Morrow M.D.</u>	23b. ADDRESS <u>State Hospital #2, City</u>	23c. DATE SIGNED <u>6-28-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>June 28, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wheeling Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Wheeling, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>July 9, 1954</u>	REGISTRAR'S SIGNATURE <u>Kathen M. Allison</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>485-7</u> <u>Brothers Funeral Home, LaCade, Mo.</u>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

2

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *W. R. Wright*

Licensed Embalmer No. *4655*

P. O. Address *Leeds, MA*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.