

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **455**

FILED JAN 10 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008** Registrar's No. **6**

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Callaway</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Fulton</b>	c. LENGTH OF STAY (In days) <b>6 days</b>	c. CITY OR TOWN <b>Fulton</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Callaway Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>710 Court St.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>William Conrad</b>	b. (Middle) <b>Calvin</b>	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <b>January 2, 1956</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 9, 1873</b>	9. AGE (In years last birthday) <b>82</b>	If UNDER 1 YEAR Months	If UNDER 1 YEAR Days	If UNDER 1 YEAR Hours	If UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work comprising most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Callaway County Mo.</b>	12. CITIZENSHIP OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Hiram Calvin</b>	13b. MOTHER'S MAIDEN NAME <b>Emma Neff</b>	14. NAME OF HUSBAND OR WIFE <b>Maude Dudley Calvin</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Paul Calvin</b>	ADDRESS <b>Houston Texas</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>  <b>you?</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive CVR</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>442X</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) m.	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 **27 Dec 1955**, to **2 Jan 1956**, that I last saw the deceased alive on **Jan 1956**, and that death occurred at **1:30 A.M.** from the causes and on the date stated above.

23a. SIGNATURE <b>T. R. Gish</b> (Degree or title) <b>MD</b>	23b. ADDRESS <b>Fulton Mo</b>	23c. DATE SIGNED <b>3 Jan 56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Jan. 3/56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>	24d. LOCATION (City, town, or county) (State) <b>Near Fulton Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Jan 7-1956</b>	REGISTRAR'S SIGNATURE <b>Martha Lawrence</b> <b>4267</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Maureen Funch Home</b>	ADDRESS <b>Fulton Mo</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

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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

*J. D. Ross*

Licensed Embalmer No. *288*

P. O. Address *.....*

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.