

-62-024475

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6581 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

FILED JUL 12 1962

1. PLACE OF DEATH a. COUNTY:		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in lb 2 days	c. CITY OR TOWN East Alton Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardinal Glennon Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 837 Amherst Drive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Michael Kevin Calhoon			4. DATE OF DEATH Month Day Year 7 2 62
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-29-62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Illinois
12. CITIZEN OF WHAT COUNTRY United States		13. FATHER'S NAME Horace N.	
13b. MOTHER'S MAIDEN NAME Joan M. Glatz		14. NAME OF HUSBAND OR WIFE Nil.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Horace N. Calhoon, 837 Amherst, Dr.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MECONIUM ILEUS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Fibrocystic Disease of PANCREAS DUE TO (c) 587.2			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 6-30-62 to 7-2-62 and last saw him alive on 7-2-62 Death occurred at 3:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J Eugene Lewis Jr MD		22b. ADDRESS 634 N. GRAND, St Louis 3.	22c. DATE SIGNED 7-2-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-5-62	23c. NAME OF CEMETERY OR CREMATORY Roselawn Memory Gardens	23d. LOCATION (City, town, or county) (State) Bethalto, Ill.
24. FUNERAL DIRECTOR Marks Funeral Home, Woodriver, Illinois.		25. DATE RECD. BY LOCAL REG. JUL 3 1962	26. REGISTRAR'S SIGNATURE Joan Smith, M.D.

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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. W. Embler*

Licensed Embalmer No. 7653
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.