

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-047278

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 2

STATE FILE NUMBER

FILED JAN 7 1964

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u> | | Length of stay in 1b <u>en route</u> | c. CITY OR TOWN <u>Scott City</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOA S.E. Mo Hosp</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|--|----------------------------------|---|--|---|---|
| 3. NAME OF DECEASED (Type or print) <u>CHARLES WILLIS CALHOUN</u> | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>23</u> Year <u>1963</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 24, 1887</u> | 9. AGE (last birthday) <u>76</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | 11. BIRTHPLACE (City and state or country) <u>Obion County, Tenn.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13a. FATHER'S NAME <u>Millard Calhoun</u> | | 13b. MOTHER'S MAIDEN NAME <u>Nancy Thorn</u> | | 14. NAME OF HUSBAND OR WIFE <u>Ethel Jones Calhoun</u> | |
| 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. [REDACTED] | 17. INFORMANT Address <u>Scott City, Mo.</u> <u>Mrs. Ethel Calhoun</u> | | |

| | | |
|--|-----------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH <u>5+ yrs.</u> <u>1 day</u> <u>5+ yrs.</u> |
| IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) | DUE TO (b) <u>Pulmonary Edema</u> | |
| DUE TO (c) <u>Arteriosclerosis</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Anemia</u> | | 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 type="checkbox"/> NO <input checked="" 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 <u>12:45</u> e.m. p.m. | Month, Day, Year <u>2/10/63</u> | |

| | | | | |
|---|--|--|------------------------|---------------------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION <u>Scott City, Mo.</u> | COUNTY <u>Scott</u> | STATE <u>Mo.</u> |
| 21. I attended the deceased from <u>2/10/63</u> to <u>12/23/63</u> and last saw him <u>alive</u> on <u>11/30/63</u> Death occurred at <u>12:45</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

| | | | |
|---|-----------------------------|---|---|
| 22a. SIGNATURE (Degree or title) <u>A. LeRoy Jones, M.D.</u> | | 22b. ADDRESS <u>24 North Sprigg Cape Girardeau, Missouri</u> | 22c. DATE SIGNED <u>12/1/63</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>1/26/63</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem</u> | 23d. LOCATION (City, town, or county) (State) <u>Cape Girardeau, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>BISPLIN HOFF FUNERAL HOME</u> | ADDRESS <u>ILLMO 140</u> | 25. DATE RECD. BY LOCAL REG. <u>1-2-1964</u> | 26. REGISTRAR'S SIGNATURE <u>James Kasten</u> |

| DO NOT WRITE ON THIS STUB | AMENDED | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | INSTEAD OF | DOCUMENT | MEDICAL CERTIFICATION | BY AFFIDAVIT OF |
|---------------------------|---------|--------------|--|------------|----------|-----------------------|-----------------|
| VS 300 Rev. 4/59 | | | | | | | |
| 1 <u>0168</u> | | | | | | | |
| 2 <u>1000</u> | | | | | | | |
| 3 <u>2</u> | | | | | | | |
| 4 <u>0</u> | | | | | | | |
| 5 <u>1</u> | | | | | | | |
| 6 | | | | | | | |
| 7 <u>1</u> | | | | | | | |
| 8 <u>0</u> | | | | | | | |
| 9 <u>500</u> | | | | | | | |
| 10 | | | | | | | |
| 11 | | | | | | | |
| 12 <u>92-0</u> | | | | | | | |
| 13 <u>1-0</u> | | | | | | | |

USE BLACK INK OR TYPEWRITER RIBBON

JAN 8 1964

0108

10001

0

1

1

0

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.

0-39

Student _____
Signature of Student Embalmer

Signed Oliver C. Amick

Licensed Embalmer No. 4470

P. O. Address Illino, 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.