

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**15564**  
**15295**

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City St. Louis (No.) City Hospital #2

File No. ....  
 Registered No. **4509**  
 St. .... Ward

**2. FULL NAME**

(a) Residence, No. 2730 Laurton St., 21 Ward.

(Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** Male **4. COLOR OR RACE** Col. **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Single

**5A. IF MARRIED, WIDOWED, OR DIVORCED:**  
 HUSBAND OF (OR) WIFE OF

**6. DATE OF BIRTH** (MONTH, DAY AND YEAR) Mar. 30, 1869

**7. AGE** YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
59 | 0 | 23

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Barber  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

**9. BIRTHPLACE** (CITY OR TOWN)..... (STATE OR COUNTRY) S. Car.

**10. NAME OF FATHER** Henry Calhoun

**11. BIRTHPLACE OF FATHER** (CITY OR TOWN)..... (STATE OR COUNTRY) S. Car.

**12. MAIDEN NAME OF MOTHER** Unknown

**13. BIRTHPLACE OF MOTHER** (CITY OR TOWN)..... (STATE OR COUNTRY) Unknown

**14. INFORMANT** (Address) Anna F. Woodard  
City Hospital #2

**15. FILED**..... 19 May 2 Stark REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH** (MONTH, DAY AND YEAR) April 23, 1928

**17.** I HEREBY CERTIFY That I attended deceased from 4/22, 1928, to 4/23, 1928 that I last saw him alive on 4/23, 1928, and that death occurred on the date stated above, at 12:35 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Myocarditis  
930

**CONTRIBUTORY (SECONDARY)** indef. 900 (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED** Not known  
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Spinal Lab  
 (Signed) Robt. H. Houser, M. D.  
 , 19 (Address) City Hosp. #2

\*State the DISEASE CAUSING DEATH, or in deaths from VICIOUS CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** St. Peters Cem. **DATE OF BURIAL** April 26 1928

**20. UNDERTAKER** W. C. Gordon Und. Co. Morgan St **ADDRESS** 2649

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

