

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

Do not use this space.

43591

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. 4222 & Holly Ave) St. _____ Ward _____

File No. _____
 Registered No. 12912

2. FULL NAME

John V. Calliatt
 (a) Residence. No. 4222 & Holly St. 10 Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Louisa Calliatt

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 28, 1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 3 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Upholstering
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer Davison Furniture & Uphol. Co.

9. BIRTHPLACE (CITY OR TOWN) St. Genevieve
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Jedius Calliatt

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Genevieve
 (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Emilia Siminot

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Mo.

14. INFORMANT Mrs. J. V. Calliatt
 (Address) 4222 & Holly Ave

15. FILED 31 1928 Wm C. Starker REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 28 1925

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1928, to Dec 28, 1928
 that I last saw him alive on Dec 28, 1928, and that death occurred, on the date stated above, at 11:08 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1. Bilateral Lobar Pneumonia

2. La Grippe

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY) La Grippe

(duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____

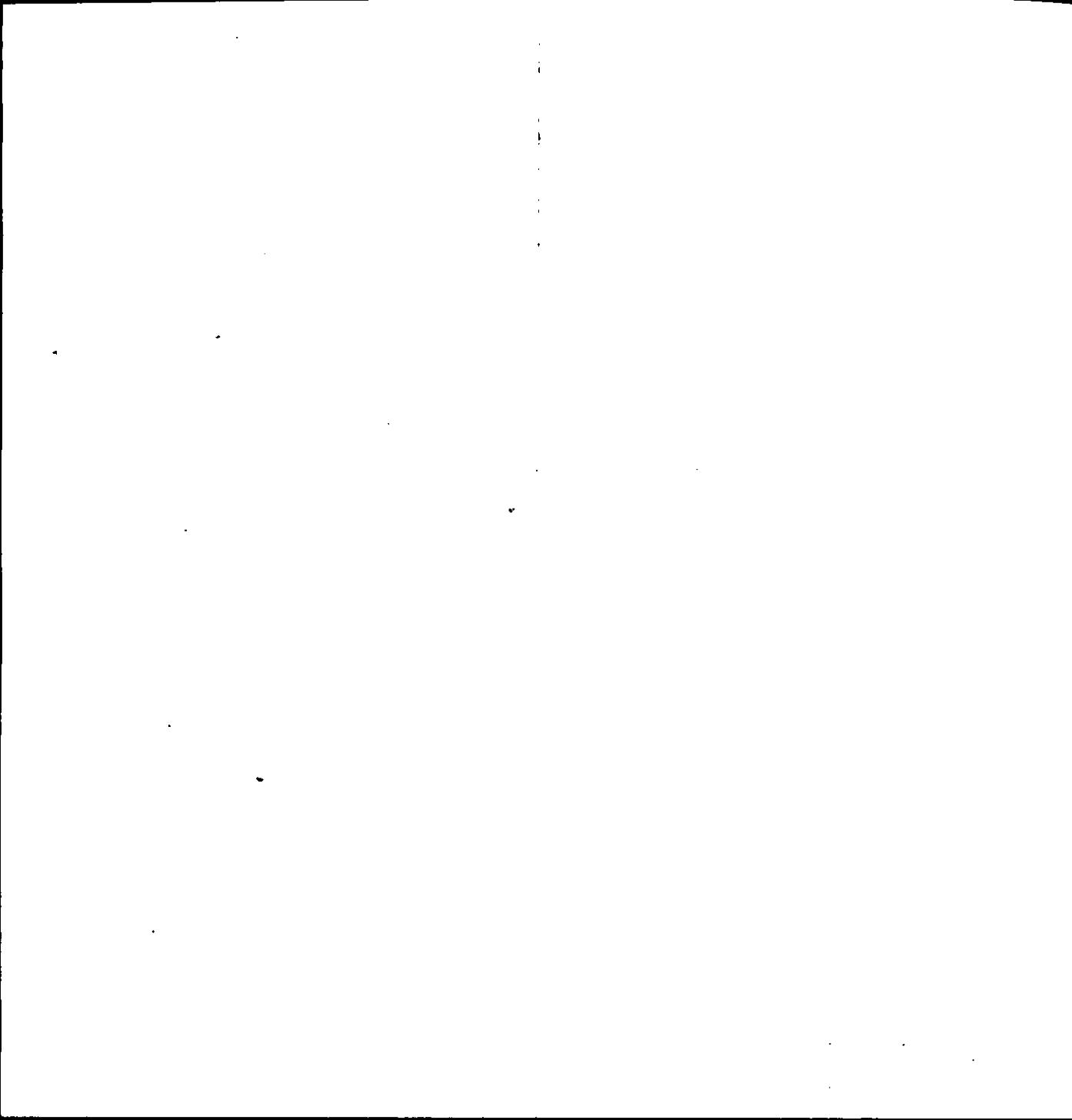
(Signed) W. O. Anderson M. D.

1229, 1928 (Address) 3108 Lewis

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL New St. Marcus DATE OF BURIAL Dec 31, 1928

20. UNDERTAKER Alton L. Co. 2707 N. Grand ADDRESS



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791 File No. 43391
 Township..... Primary Registration District No. 1003 Registered No. 12912
 City St. Louis (No.) St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

John S. Calliott

PERSONAL AND STATISTICAL PARTICULARS

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

m *w* *m*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED FEB 11 1929 *Maxl Starkeff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 28 1928

17. I HEREBY CERTIFY That I attended deceased from 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (PRIMARY) (duration) yrs. mos. ds.
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
 , 19 (Address)

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-43591