

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

Do not use this space.

38383

1. PLACE OF DEATH

County North
Township Shelburne
City Shelburne Mo (No.)

Registration District No. 904
Primary Registration District No. 4546

File No.
Registered No. 9
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.

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 Eva. Calkins

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 5 - 1845

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
84 7 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer
(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) New York

PARENTS

10. NAME OF FATHER Benjamin Calkins

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

12. MAIDEN NAME OF MOTHER Allison

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

14. INFORMANT Mr. James Calkins
(Address) Shelburne Mo

15. FILED 11/3 19 30 W. H. Johnson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 1 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct - 29 1930, to Nov 1 1930 that I last saw him alive on Oct 30 1930 and that death occurred, on the date stated above, at 7:00 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Spasmodic intercurrent nephritis
131

CONTRIBUTORY (SECONDARY) 1930 (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

18. DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Spasmodic Nephritis

(Signed) J. H. Hall M. D.

, 19 (Address) Grant City Mo

*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

Shelburne Mo 11/3 1930

20. UNDERTAKER ADDRESS

Long & Boyd, Shelburne Mo

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.

REC 31930

$$\begin{array}{r} 1930 - 11 - 1 \\ 84 \quad 3 \quad 5 \\ \hline 46 \end{array}$$

$$\begin{array}{r} 1930 - 11 - 1 \\ 1845 - 3 - 5 \\ \hline 84 - 7 - 22 \end{array}$$