

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

38975

1. PLACE OF DEATH

County Worth Registration District No. 904 File No.
 Township Union Primary Registration District No. 4546 Registered No.
 City Sheridan (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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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

Grant Calkin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 25 - 1938

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, — hrs. or — min.
75 9 4

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)

Housewife

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

10. NAME OF FATHER

William Duncan

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

14.

INFORMANT
 (Address)

Grant Calkin
Sheridan, Mo.

15.

FILED Nov 30, 1933

Mrs. Lucien Boyd
Register

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 29 1933

17.

I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1933, to Nov. 29, 1933
 (or I last saw her alive on Nov. 29, 1933, and that death occurred, on the date stated above, at 12:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Blood poisoning
59
36

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Diabetic Coma

Diabetes 15 yrs. (duration) 15 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

at place of death

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. C. Long, M. D.

, 19 (Address) Sheridan

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Sheridan Cemetery

Dec. 1 1933

20. UNDERTAKER

ADDRESS

Long & Boyd Sheridan Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.)..... St..... Ward.....

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

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

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. 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..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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

*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. (See reverse side for additional space.)

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

20. UNDERTAKER

ADDRESS