

MAR 20 1935

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

Do not use this space.

131-2B
30

1. PLACE OF DEATH

County Bollinger
Township Felton
City Max Buchanan Pa. (No. _____)

Registration District No. 69
Primary Registration District No. 5705

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Joseph Calavan
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Macklin
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 15 - 1884
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 1 21

8. Trade, profession, or particular kind of work done, as splaner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Farming
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Do not know13. NAME Do not know

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " " "

15. MAIDEN NAME " " "

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " " "

17. INFORMANT Lily Ester Buchanan Mo
(ADDRESS)18. BURIAL, CREMATION, OR REMOVAL PLACE St. Columba DATE 1-11 193519. UNDERTAKER none
(ADDRESS)20. FILED 1-15 1935 A. K. Karpatick
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-10 193422. I HEREBY CERTIFY, That I attended deceased from _____, 1934, to _____, 1934I last saw h. alive on _____, 1934. Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset _____

Heat Failure Verdict
of Coronor
Pa
Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury 1934Where did injury occur? (Specify city or town, county, and State)

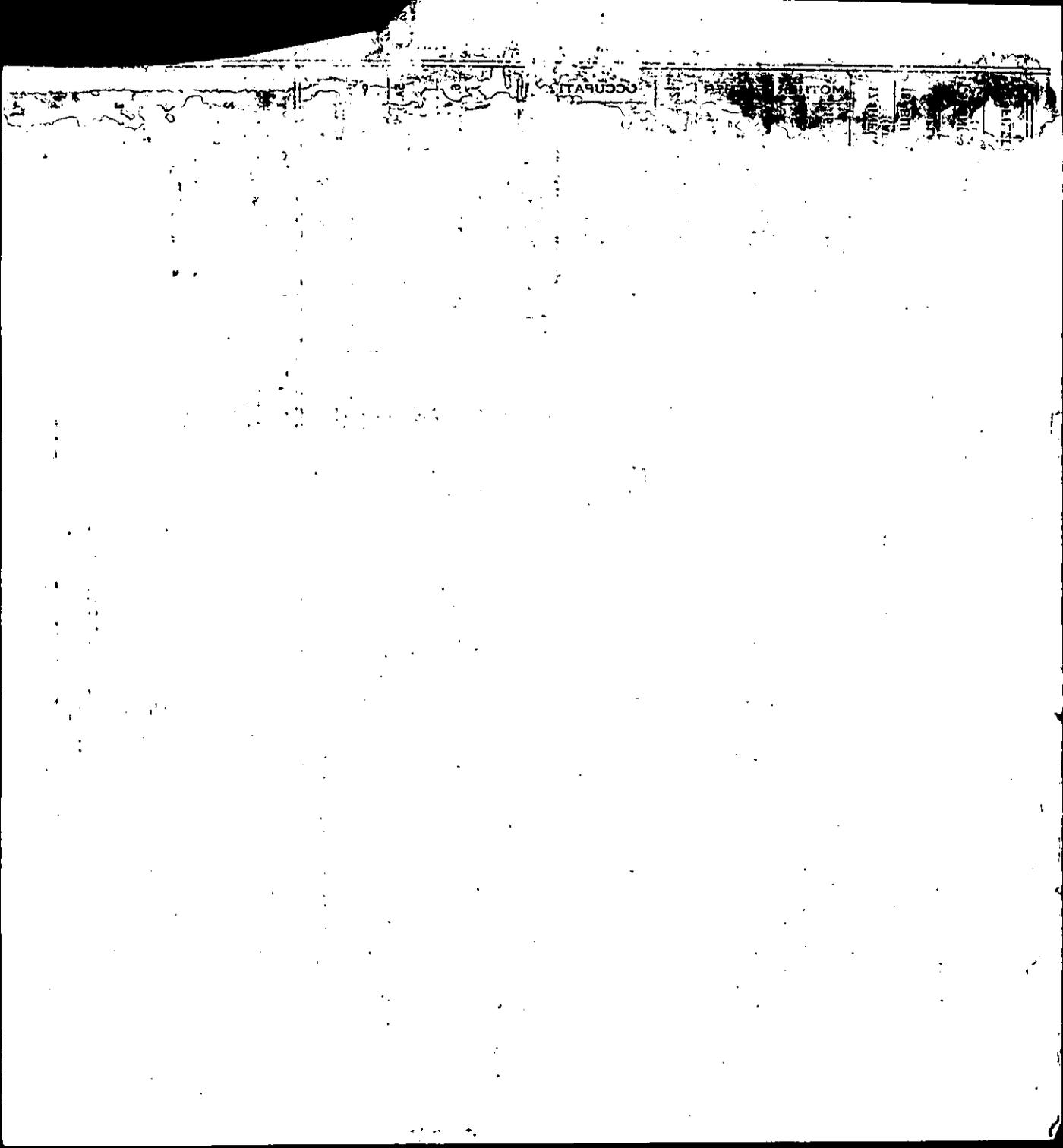
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Nature of injury 24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) J. G. Van Dusenbury, M. D.(Address) Antioch Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact



MAY 2 1 1935

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 Dollinger
Township.....
City.....

Registration District No. 69
Primary Registration District No. 5105

File No.....
Registered No. 30
St..... Ward)

2. FULL NAME

Joseph Galvan
(a) Residence, No..... St.,..... Ward.....
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-15-1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 1 26

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19.....

19. UNDERTAKER (ADDRESS)

20. FILED 1-10-35 A. G. Kerppatrick Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 10, 1934

22. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....

I last saw him/her alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Heart failure Date of onset

Organic Valvular Heart Disease

Other contributory causes of importance: 92

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

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

state. EXACTLY. PHYSICIANS should state of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY

OCCUPATION

FATHER

MC

SUPPLEMENTARY

Jan 34 at 35

MAR 26 1935

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