

JUN 13 1935

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

Do not use this space.

15444

1. PLACE OF DEATH

County Adair

Registration District No. 3

Township Walcott

Primary Registration District No. 5004

City (No.)

St. Ward)

2. FULL NAME

Stephen Ed Calif

(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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 10th 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 4 21

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Mail Carrier
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) Dec. 33 11. Total time (years) spent in this occupation

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

13. NAME Auction A. Calif.

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

15. MAIDEN NAME Minerva Spencer

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

17. INFORMANT Mr. Rebecca Calif. (ADDRESS) Libby, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Union Cemetery DATE May 7th 1935

19. UNDERTAKER F. R. Easley (ADDRESS) Buchanan, Mo.

20. FILED 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 1st 1935

22. I HEREBY CERTIFY, That I attended deceased from Apr. 29, 1935, to Apr. May 1, 1935. I last saw him alive on Apr. 30th, 1935. Death is said to have occurred on the date stated above, at 6 A.M.

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

Pneumonia
Date of onset

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

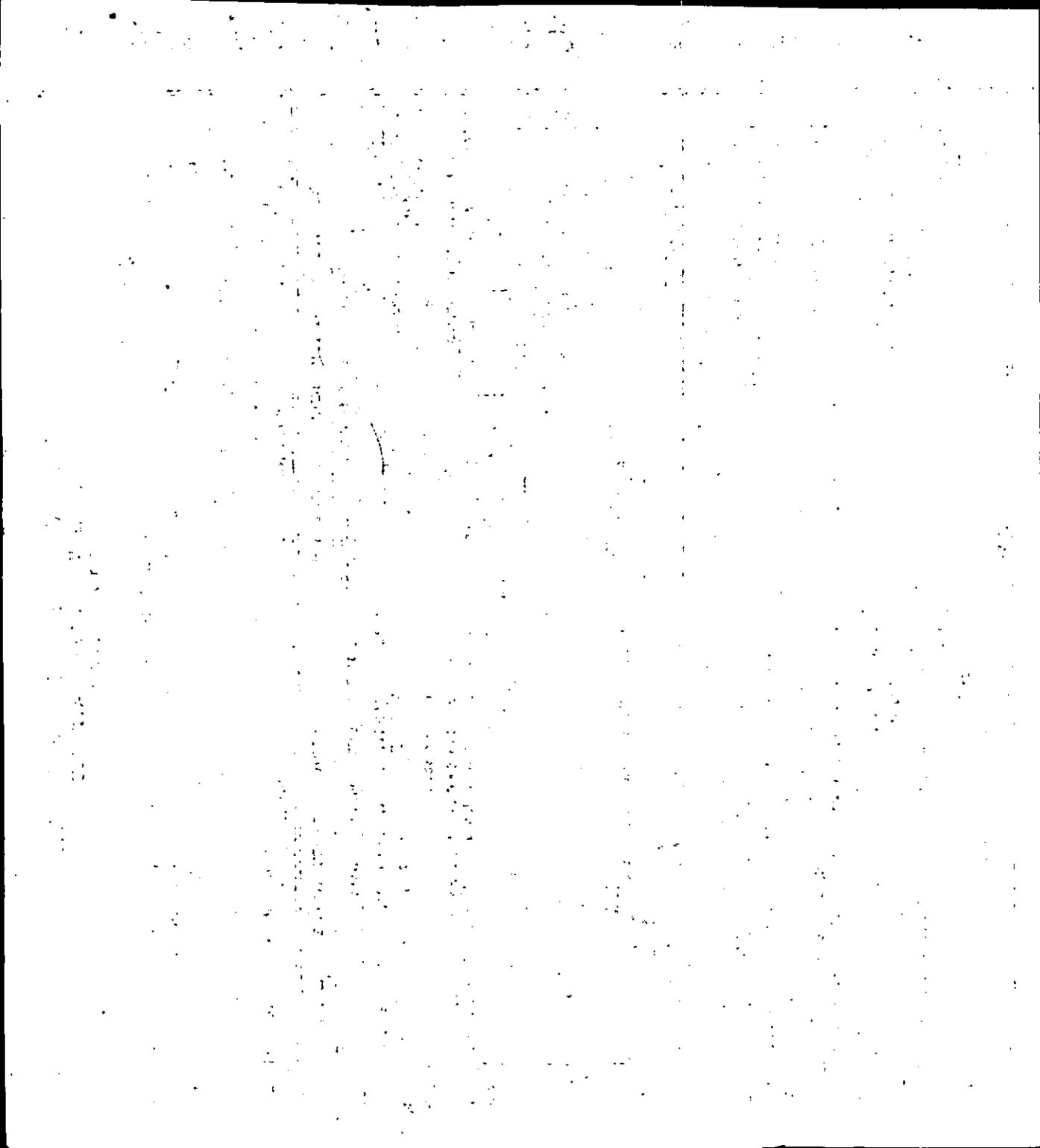
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify Y. F. Sneed, M. D.
(Signed) Thickwell, Mo.
(Address)

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.

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

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1. PLACE OF DEATH

County Adair
Township Wilson
City (No. _____) _____

Registration District No. 3
Primary Registration District No. 5004

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

2. FULL NAME

Stephen Ed. Calef

(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 m. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 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.
72 4 21

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 May 10, 1935 Alveta Collins Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 1, 1935

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

I last saw h_____ 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:

Pneumonia - labor

Date of onset

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 _____, 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) _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state

JUL 4 1935

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