

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.

OCT 6 1938 NOV 4 1938

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

Do not use this space.

36871

1. PLACE OF DEATH

County *St. Louis* Registration District No. *784*
Township *Carondelet* Primary Registration District No. *200*
City *Rock* (No. *Rock Hosp*)

File No. _____
Registered No. *1608* St. _____ Ward _____

2. FULL NAME *Donald Calloway*

(a) Residence, No. *911 Q. N. 22nd* 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. *1* mos. *2* ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Mar-23-1915*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
23 7 24

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

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

10. Date deceased last worked at this occupation (month and year) *April 1938* 11. Total time (years) spent in this occupation *22 1/2*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Charleadale Miss*

13. NAME *Albert Calloway*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Charleadale Miss*

15. MAIDEN NAME *Louise Dixon*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Charleadale Miss*

17. INFORMANT *Rock Hospital Record* (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE *Washington Pk.* DATE *Oct 9 1938*

19. UNDERTAKER *English Und. Co* (ADDRESS) *2731 Lucas Ave*

20. FILED *OCT 6 1938* *W. M. Murphy* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *10-5-1938*

22. I HEREBY CERTIFY, That I attended deceased from *9-3-38*, 19____, to *10-5-38*, 1938

I last saw him alive on *10-5-38*, 19____. Death is said to have occurred on the date stated above, at *8:40* a.m.

The principal cause of death and related causes of importance were as follows:
Pulmonary Tbc. Date of onset *Dec 1937*
Urterial Tbc.

Other contributory causes of importance: *2 3/8*

Name of operation _____ Date of _____

What test confirmed diagnosis? *Sputum* Was there an autopsy? *No*

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? *No*

If so, specify _____ (Signed) *Rand Murphy*, M. D.

(Address) *Rock Hosp*

