

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Mississippi
 (b) City or town Rural-Tywappity township
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Route #. 1.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 mo. and 19 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Sammy Calvin
 3. (c) Social Security No. X X X
 8. (b) If veteran, name war X X X

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Infant
 6. (b) Name of husband or wife Infant 6. (c) Age of husband or wife if alive X X years
 7. Birth date of deceased Jan. 28 40
(Month) (Day) (Year)

8. AGE: Years 0 Months 1 Days 19 If less than one day hr. min.

9. Birthplace Charleston, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business Infant

MOTHER FATHER { 12. Name Jim Calvin
 13. Birthplace Tupelo, Mississippi
(City, town, or county) (State or foreign country)
 14. Maiden name Ruthie Walker
 15. Birthplace Blytheville, Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Jim Calvin
 (b) Address Route 1. Charleston, Mo.

17. (a) Burial (b) Date thereof 3-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charleston, Mo.
 18. (a) Signature of funeral director John J. Munnell
 (b) Address Charleston, Mo.

19. (a) 3-19-40 (b) J. S. Vernon 745
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Mississippi
 (c) City or town Rural-Tywappity township
(If outside city or town limit, write "RURAL")
Rural Route #. 1.
 (d) Street No. Rural Route #. 1.
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 17th.
 year 1940 hour 4 minute _____ P. M.
 21. I hereby certify that I attended the deceased from Jan 28
1940, to March 1, 1940;
 that I last saw him alive on March 1, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis Duration 48 days

Due to _____
 Due to _____

Other conditions (Include pregnancy within 9 months of death) _____

Major findings: Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature Paul S. Burr (M. D. or other) _____
 Address Charleston, Mo. Date signed _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 2

District File Number 440-856

Date Filed 4/4/40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No.

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.