DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16481

Registration District No. 791 A

Primary Registration District No. 1003

Registrar's No. 3962

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Luke's Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Paitte

(c) City or town Mansfield NR (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME CALVIN W. Alvis 412

3. (b) If veteran, name war Unknown

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mollie

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased Sept. (Month) 7 (Day) 1889 (Year)

8. AGE: Years 50 Months 7 Days 24 If less than one day hr. min.

9. Birthplace Marion Co. (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name P.P.Alvis
13. Birthplace Marion Co. (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Badie Pain
15. Birthplace Marion Co. (City, town, or county) Illinois (State or foreign country)

16. (a) Informant's own signature Robert F. Alvis

(b) Address Mohamet, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-2-40 (Month) (Day) (Year)

(c) Place: burial or cremation Mansfield, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) MAY 2 1940 (Date received local registrar) (b) J. F. Bradrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1 year 1940 hour 7 minute 20 P M.

21. I hereby certify that I attended the deceased from April 15, 1940, to May 1, 1940, that I last saw him alive on May 1, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral edema

Due to Craniotomy

Due to

Other conditions Paralysis agitans (Include pregnancy within 3 months of death)

Major findings: Of operations Chr. arachnoiditis

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Cecil G. Aker (M. D. or other) M.D.

Address St. Luke's Hospital, St. Louis Date signed 5/1/40

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Rev. 5-17-39 I X19511

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. 2971

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.