No. 2
2-10-39
17-39
X21492

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

FILED AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24101

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 2714

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 Days (Specify whether years, months or days)
In this community: Non-Resident

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Shelby
(c) City or town: Shelbina
(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: Raymond G. Calvin
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Pauline
6. (c) Age of husband or wife if alive: about 31 years
7. Birth date of deceased: 12- (Month) 19- (Day) 1903 (Year)
8. AGE: Years 36 | Months 6 | Days 18 | If less than one day hr. min.
9. Birthplace: Hamilton (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Laborer
11. Industry or business: Mo. State Highway Dept
MOTHER FATHER
12. Name: Marion G. Calvin
13. Birthplace: Warrenton (City, town, or county) Missouri (State or foreign country)
14. Maiden name: Bertha Smith
15. Birthplace: Hamilton (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Mrs Calvin
(b) Address: Shelbina Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-9-1940 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~: Hamilton Mo.
18. (a) Signature of funeral director: Henry W. Stahl
(b) Address: 815 W. Maple Ave - Independence
19. (a) July 7, 1940 (Date received local registrar) (b) M M Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7-7-40 day
year hour 1:00 minute P. M.
21. I hereby certify that I attended the deceased from
to , 19 ;
that I last saw alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death: Bronchopneumonia (left)
Due to: Pt. Lemo-pneumo thorax
Due to: Trauma of 9th & 10th ribs on right
Other conditions (Include pregnancy within 3 months of death): Laceration of lung & pleura
Auto trauma
Major findings:
Of operations:
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): Accident
(b) Date of occurrence: 7-4-40
(c) Where did injury occur? K. C. (City or town) Jackson (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Creek
While at work (Specify type of place) (Specify type of business)
(e) Means of injury: Auto
23. Signature: Arthur M. Miller (M. D. or other)
Address: K. C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

218 M
98

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 Henry W. Stahl

Licensed Embalmer No. 3181

P. O. Address Independence M

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

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

No. 2B
2-21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No. 2714

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)

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

In this community

3. (a) PRINT FULL NAME Raymond G. Calvert

3. (b) If veteran, name war 1/1

3. (c) Social Security No.

4. Sex

5. Color or race

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

6. (b) Name of husband or wife

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

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

8. AGE: Years | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

13. Birthplace (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) July 7, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7th year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia

Int. Hemo Pneumothor ax

Fracture of 9th & 10th ribs

Due to on right a d laceration of lungs and pleura.

Due to Auto traumatism

Other conditions (Include pregnancy within 3 months of death)

Major findings: Report from Highway Patrol:

Of operation Collision with another automobile on

Of autopsy Sterling Ave. in Sugar Creek, Mo.

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) Acc.

(b) Date of occurrence 7-4-40 Jackson Co

(c) Where did injury occur? Sugar Creek, Mo. (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 (M. D. or other)

Address Date signed

S-24104