

JUL 10 1942
Registration District No. 234

Primary Registration District No. 10097

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Rural - ~~Stoddard~~
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1 Mile North East of Bell City
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard 103
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 1 Mile N. East of Bell City 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Robert E. Calvin
3. (b) If veteran, name war Peace Time Soldier 3. (c) Social Security _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 6 day 27
year 1942 hour 5 minute 30 M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, 2 divorced, Widowed
8. (b) Name of husband or wife _____ 8. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 10 5 1887
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 0 saw him once 8/10 1942 to _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
54 8 22 _____ hr. _____ min.

Immediate cause of death Dropsy Duration _____

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

Due to Valvular Insufficiency of the heart
Due to _____

10. Usual occupation Farming

Other conditions _____
(Include pregnancy within 5 months of death) 95c²

MOTHER FATHER

11. Industry or business _____
12. Name W.B. Calvin
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Dora Pearman
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy no autopsy
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Oscar Calvin
(b) Address Bell City Mo.

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? _____

17. (a) Burial (b) Date thereof 6/28/42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sikeston Mo.

While at work? _____ (Specify type of place) (e) Means of injury _____

18. (a) Signature of funeral director H.W. Albritton
(b) Address Sikeston Mo.

23. Signature C.O. Bennett (M. D. or other) _____
Address Bell City, Mo Date signed _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

1131

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

13
0
0

2

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.....

Embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Hunter Albritton

Licensed Embalmer No. **4210**

P. O. Address **Sikeston Mo.**

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22433

Registration District No. 834

Primary Registration District No. 6097

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
years, months or days)

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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Robert E Calvin
3. (b) If veteran, name war..... 3. (c) Social Security No.....

20. DATE OF DEATH: Month June day 17
year 42 hour..... minute..... M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Oct 5 1888
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from.....
that I last saw him/her alive on....., 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

8. AGE: Years 54 Months 8 Days 12 min.
If less than one day

Duration
Due to.....
Due to.....

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

Other conditions.....
(Include pregnancy within 3 months of death)

10. Usual occupation.....
11. Industry or business.....

Major findings:
Of operations.....
Of autopsy.....
PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

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

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) 8-13-42 (b) M.R.T. Brown
(Date received local registrar) (Registrar's signature)

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..... (M. D. or other).....
Address..... Date signed.....

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

SUPPLEMENTARY

S-22433