

No. 2
4-15-40
5-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13959

State File No. _____

FILED APR 20 1943
Registration District No. 55

Primary Registration District No. 5186 4091

Registrar's No. _____

1. PLACE OF DEATH:
(a) County CARROLL Co
(b) City or town BOSWORTH MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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: 17
(a) State MO (b) County CARROLL Co
(c) City or town BOSWORTH MO
(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.? 0 years.

3. (a) PRINT FULL NAME THOMAS ARTHUR CALVERT
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 7
year 1943 hour 3 minute _____ A. M.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced SD
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 2 1943
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mar 6 1943 to Mar 6 1943
that I last saw him alive on Mar 6 1943
and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months _____ Days 5 If less than one day hr. _____ min. _____

Immediate cause of death Paracorditis ✓
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

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

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

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER
12. Name Thomas Clinton Calvert
13. Birthplace Bosworth MO
(City, town, or county) (State or foreign country)
14. Maiden name Georgia Eloise Finley
15. Birthplace Hale MO
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas C. Calvert
(b) Address Bosworth 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, cremation, or removal) _____ (b) Date thereof 3-8-43
(Month) (Day) (Year)
(c) Place: burial or cremation BIS CREEK CEMETERY

18. (a) Signature of funeral director David P. Edwards
(b) Address Bosworth MO

While at work? _____ (Specify type of place)
(a) Means of injury _____
23. Signature Paul Perry Edwards (M. D. or other) MO
Address Bosworth MO Date signed Mar 8 1943

19. (a) March 8 1943 (b) Paul Perry Edwards
(Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

4-19-43

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 _____

David J. Edmunds

Licensed Embalmer No. _____

3265

P. O. Address _____

Barnworth, N.C.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1395-9
Registrar's No. _____

Registration District No. 5-5

Primary Registration District No. 4081

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Bosworth
(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) (Specify whether
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 Thomas A. Calvert
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 3
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased Feb 2 - 1943
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry of business _____

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb _____ day _____
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
that I have seen him _____ live on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to pericarditis
of bacterial
infective

Due to _____

Other conditions _____

(Includes pregnancy within 3 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)

(a) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

