

3. No. 2  
4-5-42  
5-17-39  
1 x 12

FILED SEP 25 1943 128

Registration District No. **128**

Primary Registration District No. **2000**

1. PLACE OF DEATH:

(a) County **GREENE**  
(b) City or town **Springfield,**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**712 State**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **None**  
In this community **3 years**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene 037**  
(c) City or town **Springfield**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **712 State**  
(If rural, give location)  
(e) Citizen of foreign country? **(Yes or No)**  
If yes, name country **( )**

3. (a) PRINT FULL NAME

**William S. Calhoun**

3. (b) If veteran, name war **Unknown**

3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Grace Harriett Calhoun**  
6. (c) Age of husband or wife if alive **Unknown** years  
7. Birth date of deceased **January 9, 1869**  
(Month) (Day) (Year)

8. AGE: Years **74** Months **7** Days **25**  
If less than one day hr. min.

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

10. Usual occupation **Dentist**

11. Industry or business **Dentistry**

12. Name **James F. Calhoun**  
13. Birthplace **Unknown Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Lucinda Elms**  
15. Birthplace **Unknown Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **R. L. Calhoun**  
(b) Address **Springfield, Missouri**

17. (a) **Removal** (b) Date thereof **Sept. 6, 1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Waverly, Kansas**

18. (a) Signature of funeral director **Alma Lohmeyer Funeral Home**  
(b) Address **Springfield, Missouri**

19. (a) **9-11-43** (b) **W. Standley**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **4**  
year **1943** hour **5:30** minute **P.** M.

21. I hereby certify that I attended the deceased from **Aug. 28, 1943** to **Sept. 4, 1943**  
that I last saw him **alive on Sept. 4, 1943**  
and that death occurred on the date and hour stated above.

Immediate cause of death **acute gastro-enteritis 10 days**  
Due to **bacillary infection**

Due to **Ch. degenerative cardio-vascular disease**

Other conditions **Ch. degenerative cardio-vascular disease**  
(Include pregnancy within 3 months of death)  
Major findings: Of operations **1200V**  
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? **( )**

23. Signature **Arthur D. Knott** (M. D. or other) **MD**  
Address **450 1/2 E. Conley** Date signed **9-11-43**  
**Sept. 11, 1943**

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

MOTHER FATHER

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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, fact should be so stated above.

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