

FILED JUN 2 1944  
Registration District No. 176

Primary Registration District No. 49475947

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town St James 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

3. (a) PRINT FULL NAME William L Calvin

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male

5. Color or face White

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

6. (b) Name of husband or wife Oliver Calvin

6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased 3 - 7 - 1865  
(Month) (Day) (Year)

8. AGE: 79 Years    Months 2    Days 2    If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Job Calvin

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

14. Maiden name Margie Murrell

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

16. (a) Informant Ollie Calvin

(b) Address St James Mo

17. (a) Rural (b) Date thereof 5-11-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove

13. (a) Signature of funeral director W E Beckler

(b) Address St James Mo

19. (a) 5-18-1944 (b) Chance Dickson  
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps

(c) City or town St James Rural  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 9  
year 1944 hour 12:30 minute 0 M.

21. I hereby certify that I attended the deceased from June 1944 to May 9 1944  
that I last saw him alive on May 9 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 2 days  
Chronic Hypertension 3 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: of 30

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) (e) Means of injury \_\_\_\_\_

23. Signature William L Calvin (M. D. or other) \_\_\_\_\_  
Address St James Mo Date signed 5/16/44

Duragon

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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 W. E. Luckless

Licensed Embalmer No. 1990

P. O. Address St James Md

**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.**