

FILED SEP 13 1944

Registration District No. 114

Primary Registration District No. 4186

Registrar's No. 33

36
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County FRANKLIN
(b) City or town SULLIVAN
(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 _____
In this community LIVE 27 years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME JOSEPH CALVIN

8. (b) If veteran, name war NO 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nora Calvin 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased December 28, 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 8 1 hr. _____ min.

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

10. Usual occupation Section Foreman

11. Industry or business Railroading

MOTHER FATHER
12. Name Calvin
18. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Thompson
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nora Calvin
(b) Address Sullivan, Missouri.

17. (a) Burial (b) Date thereof Aug. 31, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sullivan, Missouri.

18. (a) Signature of funeral director [Signature]
(b) Address Sullivan, Missouri.

19. (a) 8-31-44 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County FRANKLIN
(c) City or town SULLIVAN
(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 August day 29
year 1944 hour 2 minute 05 P. M.

21. I hereby certify that I attended the deceased from 12 P.M. 8-29, 1944, to 8-29, 1944; that I last saw him alive on August 29, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis

Due to _____
Due to _____

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

Major findings: Of operations No Operation
Of autopsy No 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 5

23. Signature [Signature] (M. D. or other) _____
Address Sullivan, Missouri. Date signed 8/31/44

Duration

Three

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 22 1944

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed _____

9-12-44

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 _____

Edgar W. Laffoon

Licensed Embalmer No. _____

3394

P. O. Address _____

Sullivan Mo

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.