

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 42368FILED JAN 12 1945
Registration District No. 375Primary Registration District No. 6279Registrar's No. 67

1. PLACE OF DEATH:

- (a) County Wright
 (b) City or town Hartville Rural Gasconade T.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: At his home
5 1/2 miles southwest of Hartville
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None (Specify whether
 In this community 64 Yrs. years, months or days)

3. (a) PRINT FULL NAME GEORGE WASHINGTON CALHOUN3. (b) If veteran, name war _____ 3. (c) Social Security No. None4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Ada Jane Calhoun 6. (c) Age of husband or wife if alive 58 years7. Birth date of deceased 11 1 1879
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
64 11 29 hr. min.9. Birthplace Mansfield Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business _____

12. Name Wm. Calhoun13. Birthplace Mo.
(City, town, or county) (State or foreign country)14. Maiden name Martha Moody15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____

(b) Address _____

17. (a) Burial (b) Date thereof 11 2 44
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Wolf Creek Cem.18. (a) Signature of funeral director Gene E. Holden(b) Address Hartville, Mo19. (a) Jan 3, 1945 (b) W. T. Nunn
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County Wright 114
 (c) City or town Hartville Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5 1/2 miles South west of Hartvil
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. Born in U.S.A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 31
year 1944 hour 2:00 minute 10 A.M.21. I hereby certify that I attended the deceased from Aug.
1943 to Oct 19 44
that I last saw him alive on Sept 7 19 44
and that death occurred on the date and hour stated above.Immediate cause of death Chromomyocarditis
Chromomyocarditis and
arterial hypertension
Due to _____
Due to _____Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations 131

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 P. M. Norman (M. D. or other) _____
Address Ada Mo Date signed Nov 19 44

RECEIVED

District Health Officer No. 6;

District File Number 145-6

Date Filed JAN 9 1945

JAN 17 1945

JUN 30 1946

JUL 21 1948

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 Gene E. Holdren

Licensed Embalmer No. 3865

P. O. Address Hartsville, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 375

Primary Registration District No. 6279

Registrar's No. 67

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Rural Garwood
(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

George W. Calhoun

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 m

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Jan (Month) _____ (Day) _____ (Year)

8. AGE: Years 64 Months _____ Days _____ If less than one day, _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or 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 Clara Van Ness

(b) Address Hartsville, Mo

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1944 Hour _____ minute _____ M.

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

Due to _____
Due to _____

Other conditions: _____ (Include 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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-42368 1944