DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1233

FILED JAN 31 1946

Registration District No. 1409 Primary Registration District No. 1002 Registrar's No. 245

1. PLACE OF DEATH:
(a) County: JACKSON
(b) City or town: KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital ~~or institution~~: ST JOSEPH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or ~~institution~~ 9 DAYS (Specify whether years, months or days)
In this community 79 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: JACKSON 49
(c) City or town: KANSAS CITY 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 1113 EAST 5TH STREET 8
(If rural, give location) 0
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: MRS. CNEMIE CALVERT
3. (b) If veteran, name war: NO
3. (c) Social Security No.: NONE
4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: WIDOWED
6. (b) Name of husband or wife: MR. BENJAMIN CALVERT
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: FEBRUARY 15 1866 (Month) (Day) (Year)

8. AGE: Years 79 Months 10 Days 29 If less than one day hr. min.

9. Birthplace: PLATTE COUNTY (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation: AT HOME
11. Industry or business:
MOTHER FATHER
12. Name: THOMAS HERNDON
13. Birthplace: CULPEPPER COUNTY (City, town, or county) VIRGINIA (State or foreign country)
14. Maiden name: UNKNOWN
15. Birthplace: UNKNOWN (City, town, or county) (State or foreign country)
16. (a) Informant: MR. JOHN B. CALVERT
(b) Address: 702 EAST 11ST ST. TERRACE
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: JAN 15 1946 (Month) (Day) (Year)
(c) Place: burial or cremation: FOREST HILL VAULTS
18. (a) Signature of funeral director: D. H. Funeomers Sons
(b) Address: 1401 BRUSH CREEK BLVD.
19. (a) 1-16-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 14th year 1946 hour 3 minute 36 A M.
21. I hereby certify that I attended the deceased from Jan 5, 1946, to Jan 14, 1946, that I last saw h. alive on Jan 12, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia — 1 day
Due to: Chronic cellulitis — 1 day
Due to: Acute congestive heart failure — 2 days
Due to: Diabetes — 2 days
Due to: Hypostatic bronchopneumonia — 2 days
Other conditions (Include pregnancy within 3 months of death): Intracapsular fracture — 9 days
Major findings:
Of operations: Fractured neck of femur
Of autopsy: X Feb 5, 1946

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): Accident
(b) Date of occurrence: 1-4-46 12:5
(c) Where did injury occur? K. C. (City or town) Jackson (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? At home (Specify type of place)
While at work? no (e) Means of injury: fall
23. Signature: [illegible] (M. D. or other)
Address: [illegible] Date signed: 1-15-1946

(Licensed Embalmer's Statement on Reverse Side)

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149 Primary Registration District No. 1002. Registrar's No. 245

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City.
(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 years, months or days)

In this community

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 Clemie Calvert

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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

6. (b) Name of husband or wife

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

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

8. AGE: Years 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

MOTHER FATHER

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) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-46 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director

(b) Address

19. (a) 1-16-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 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 — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

1233